



# COMMONWEALTH of VIRGINIA

## DEPARTMENT OF SOCIAL SERVICES

March 3, 2004

MEDICAID MANUAL – VOLUME XIII

TRANSMITTAL #76

The following acronyms are used in this transmittal:

- ABD – Aged, Blind, and Disabled
- AC – Aid Category
- CNNMP – Categorically Needy Non-Money Payment
- F&C – Families and Children
- FAMIS – Family Access to Medical Insurance Security Plan
- FPL – Federal Poverty Limit
- INS – Immigration and Naturalization Service
- IRWE/BWE – Impairment-related Work Expense/Blind Work Expense
- LIFC – Low Income Families with Children
- LTC – Long-term Care
- MI – Medically Indigent
- MMIS – Medicaid Management Information System
- PD – Program Designation
- QDWI – Qualified Disabled Working Individuals
- QI – Qualified Individuals
- QSII – Qualified Severely Impaired Individuals
- SAVE – Systematic Alien Verification for Entitlements
- SS – Social Security
- SSA COLA – Social Security Administration Cost of Living Adjustment
- SSI – Supplemental Security Income
- USCIS – United States Citizenship and Immigration Services
- VaMMIS – Virginia Medicaid Management Information System

This transmittal contains the January 2004 SSA COLA, the changes in Medicare premiums, the income limits and deeming allocations based on the SSI payment levels, the ABD student child earned income exclusion, the average monthly private nursing facility cost, and the LTC resource and maintenance standards. The new amounts, which were released in Broadcast 2468, must be used for all Medicaid eligibility determinations effective on or after January 1, 2004.

This transmittal also contains the new MI and FAMIS income limits. The new income limits were effective February 13, 2004 for all F&C MI, ABD MI without SS, and FAMIS eligibility determinations. The new income limits are effective April 1, 2004, for all ABD MI with SS eligibility determinations.

This transmittal includes a description of some of the new terminology used in the VaMMIS. For example, a PD is now referred to as an AC and the MMIS is now referred to as the VaMMIS.

Because it is not feasible to replace the old MMIS terminology with the new VaMMIS terminology throughout the Medicaid Eligibility Manual, please use these terms interchangeably where there are enrollment instructions in the manual.

Clarifications to policy in this transmittal include: alien status verification; real property requirements for QSII; determining eligibility in the ABD MI with Income  $\leq$  80% FPL covered group; exemption of the former home for individuals in medical institutions; Title IV-E adoption assistance reviews; foster care case maintenance; enrollment of children on the 12-month extension; and alienage requirements and creditable health coverage for FAMIS eligibility determinations. Except as noted above, all policy clarifications and updates contained in this transmittal are effective for all eligibility determinations completed on or after April 1, 2004.

Remove and Destroy Pages	Insert Attached Pages	Significant Changes
Subchapter M0130 pages 7, 8	Subchapter M0130 pages 7-9	On page 7, revised the information on the Medicaid enrollment system. Page 8 is a runover page. On page 9, clarified treatment of duplicate applications.
Subchapter M0220 pages 5, 6	Subchapter M0220 pages 5, 6	On pages 5 and 6, revised the name of INS to USCIS. On page 6, also clarified the process for retention of the G-845 form and that agencies must not delay processing or take negative action while awaiting a secondary SAVE verification.
Subchapter M0310 pages 21, 22	Subchapter M0310 pages 21, 22	On page 21, clarified policy on children living in a residential facility. Page 22 is a reprint.
Subchapter M0320 pages 11, 12 pages 19, 20 pages 43, 44	Subchapter M0320 pages 11, 12 pages 19-20a pages 43, 44	Page 11 is a reprint. On page 12, added the COLA and Medicare premiums for January 2004. On pages 19 and 20, clarified that QSII - 1619(B) individuals must continue to meet the real property resource requirements for Medicaid. Page 20a is a runover page. On page 43, revised enrollment information for QDWI to reflect the new VaMMIS system. On page 44,

Remove and Destroy Pages	Insert Attached Pages	Significant Changes
		clarified that the ABD with Income $\leq$ 80% FPL covered group is limited to individuals who do not meet another full benefit covered group.
Subchapter M0520 pages 1, 2 pages 5, 6	Subchapter M0520 pages 1, 2 pages 5, 6	Page 1 is a reprint. On pages 2 and 5, clarified policy on children living in a residential facility. Page 6 is a reprint.
Subchapter M0530 page 49 (Appendix 1)	Subchapter M0530 page 49 (Appendix 1)	On page 49, updated the deeming allocations based on the January 2004 SSI payment levels.
Subchapter M0710 pages 5, 6 Appendix 6, pages 1, 2 Appendix 7, page 1	Subchapter M0710 pages 5, 6 Appendix 6, pages 1, 2 Appendix 7, page 1	On page 5, corrected text. Page 6 is a reprint. In Appendix 6 and Appendix 7, updated F&C income limits based on the February 13, 2004 FPL.
Subchapter M0810 pages 1, 2	Subchapter M0810 pages 1, 2	On page 1, updated the income limits for CNNMP protected groups based on the 2004 SSI payment levels. On page 2, updated the 300% SSI income limit and also updated the ABD MI income limits.
Subchapter S0820 pages 29-32	Subchapter S0820 pages 29-32	On page 29, revised reference to IRWE/BWE. On page 30, updated the ABD student child earned income exclusion. On page 31, added the January 2004 figures for the ABD student child earned income exclusion. Page 32 is a reprint.

Remove and Destroy Pages	Insert Attached Pages	Significant Changes
Subchapter M1450 pages 31, 32	Subchapter M1450 pages 31, 32	On page 31, added the average monthly private nursing facility costs for January 2004. Page 32 is a reprint.
Subchapter M1460 pages 3-6 pages 13, 14 pages 17, 18 pages 21-26 pages 35, 36	Subchapter M1460 pages 3-6 pages 13, 14 pages 17, 18 pages 21-26 pages 35, 36	Pages 3 and 6 are reprints. On pages 4, 5, 13, 14, 17 and 18, clarified that the hierarchy for evaluating ABD individuals in long-term care begins with the 300% SSI covered group. On page 21, clarified that an adult child or parent under the age of 65 who has been found by Civil Service to be disabled meets the “disabled” criteria for purposes of exempting the former home. Pages 22 and 23 are reprints. On pages 24 and 25, revised references to QI. On page 35, updated the ABD student child earned income exclusion. Page 36 is a reprint.
Subchapter M1480 Table of Contents, pages i, ii pages 17, 18 pages 43-46 pages 49-50a pages 65, 66	Subchapter M1480 Table of Contents, pages i, ii pages 17, 18 pages 43-46 pages 49-50a pages 65, 66	Revised page i in the Table of Contents. Page ii is a reprint. Page 17 is a reprint. On page 18, added the January 2004 spousal resource standard figures. On pages 43, 44 and 46, revised references to QI. Page 45 is a reprint. On pages 49-50a, clarified that the hierarchy for evaluating individuals in long-term care begins with the 300% SSI covered group. Page 65 is a reprint. On page 66, added the January 2004 monthly maintenance needs allowance maximum.

Remove and Destroy Pages	Insert Attached Pages	Significant Changes
Subchapter M1520 Table of Contents pages 1-14 pages 23, 24	Subchapter M1520 Table of Contents pages 1-14 pages 23, 24	Revised the Table of Contents. Page 1 in a reprint. On page 2 expanded who can report the birth of a newborn child. On page 3, clarified the real property requirements for QSII. On pages 3-10, revised the redetermination requirements. Page 11 is a reprint. On page 12, deleted the references to mailing of monthly Medicaid cards. On page 13, clarified that children who meet the MI Child Under Age 19 covered group should be enrolled as MI. Only children who no longer meet the MI covered group should be enrolled as LIFC-extended. Page 14 is a reprint. Page 23 is a reprint. On page 24, clarified that foster care and adoption assistance cases are not transferred unless custody or responsibility for services and payment are transferred.
Chapter M16 pages 3-8 Appendix 1, pages 15-17	Chapter M16 pages 3-8 Appendix 1, pages 15-17	Page 3 is a reprint. On pages 4-8, clarified the appeals process. Appendix 1, page 15 is reprint. On Appendix 1, pages 16, revised the Agency Appeal Summary instructions to include FAMIS. On Appendix 1, page 17, clarified the appeals process.
Chapter M21 Table of Contents pages 1-6 Appendix 1, page 1 Appendix 4, pages 1-5	Chapter M21 Table of Contents pages 1-6 Appendix 1, page 1 Appendix 4, pages 1-5 Appendix 7, pages 1, 2	Revised the Table of Contents. Page 1 is a reprint. On page 2, corrected the period for dropping insurance. On page 3, revised the alienage requirements. Pages 4 and 4a are runover pages. On page 5, clarified that health insurance coverage with no providers in the applicant's geographical area is not creditable

---

Remove and Destroy Pages

Insert Attached Pages

Significant Changes

---

insurance. On page 6, revised the example for discontinued health insurance coverage. In Appendix 1, updated the income limits for FAMIS based on the February 13, 2004 FPL. In Appendix 4, revised the Application for Children's Health Insurance in Virginia (FAMIS-1). Appendix 7, FAMIS Alien Eligibility Chart, is added.

Please retain this transmittal letter in the back of Volume XIII.



Duke Storen, Director  
Division of Benefit Programs

Attachments

- The income limits appropriate to the covered group must be met.

Subchapter M0210 contains the general principles of Medicaid Eligibility determination.

**B. Hierarchy of Covered Group**

An applicant must be evaluated for eligibility in all potential covered groups and enrolled in the group that is the most beneficial to the applicant. First, evaluate under covered groups offering full coverage and if the applicant is not eligible, evaluate under groups offering partial coverage. Further specific instructions regarding the determination of covered group are contained in chapter M03.

**C. Applicant's Choice of Covered Group**

An individual who meets more than one covered group may choose the covered group under which he wishes his eligibility determined. Appropriate policy used is based on that individual's choice. If the choice is not clear on the application/redetermination form, the individual must state his covered group choice in writing. If the applicant does not make a choice, enroll him in the covered group that is the most beneficial.

**D. Application Disposition**

**1. General Principle**

Each application must be disposed of by a finding of eligibility or ineligibility as supported by the facts in the case record, unless the application is withdrawn or terminated (see M0130.400).

**2. Enrollment**

Medicaid cases must be enrolled in the Medicaid Management Information System (MMIS). *Effective June 16, 2003, a new MMIS system, known as Virginia Medicaid Management Information System (VaMMIS) was implemented. The Medicaid Eligibility Manual contains enrollment instructions based on the former MMIS. Some terminology and procedures used in the VaMMIS differ from those used with the former MMIS. When following enrollment instructions in this manual, please note the following changes:*

- *The program designation (PD) is now known as aid category (AC). The AC is now the former PD prefaced by the digit "0." (e.g. AC 051).*
- *Coverage types are no longer used to enroll limited periods of coverage. Coverage is determined by begin and end dates.*
- *The former cancel reasons are now prefaced by the digit "0" (e.g. cancel reason 007).*

When enrolling an individual in *VaMMIS*, the appropriate *aid category AC* for the applicant's covered group must be used. Enrollment procedures and a list of *ACs* are found in the *Virginia MMIS User Manual*.

**3. Notification  
to Applicant**

The Notice of Action on Medicaid and Family Access to Medical Insurance Security Plan (FAMIS) Programs (NOA), form #032-03-008 (see M0130, Appendix 1) must be used to notify the applicant when:

- the application has been approved, including the effective date(s) of his Medicaid coverage;
- the retroactive Medicaid coverage was approved, including the effective dates;
- the application has been denied, including the specific reason(s) for denial cited from policy;
- retroactive Medicaid coverage was denied, including the specific reason(s) for denial cited from policy;
- there is a reason for delay in processing his application;
- a request for re-evaluation of an application in spenddown status has been completed; and
- a child has been approved or denied (including the specific reason for denial cited from policy) for FAMIS (see M21).

A copy of the notice must also be mailed to the individual who has applied on behalf of the applicant.

**E. Notification for  
Retroactive  
Entitlement**

There are instances when an applicant is not eligible for ongoing eligibility but is eligible for retroactive benefits or a change in the applicant's situation during the application process results in the applicant being eligible for only a limited period of time. Only one NOA is sent to the applicant covering both actions. Statements of the exact dates of eligibility, the date of ineligibility, and the reason(s) for ineligibility must be included on this notice.

**M0130.400 Applications Denied Under Special Circumstances**

**A. General  
Principle**

When an application is withdrawn or the applicant cannot be located, the application is denied. The reason for the denial must be recorded in the case record, and a Notice of Action on Medicaid must be sent to the applicant's last known address.

**B. Withdrawal**

An applicant may withdraw his application at any time. The request must be written and documented in the record. When the applicant withdraws an application, the eligibility worker must send a Notice of Action on Medicaid.

An applicant may voluntarily withdraw only his application for retroactive coverage by signing a statement specifically indicating the wish to withdraw the retroactive coverage part of the application.



**C. Inability to Locate**

The agency must send a letter to the last known address informing the applicant of the agency's attempt to locate him and asking that he contact the office. For applicants who are documented as homeless, maintain all correspondence at the local agency. If the applicant does not respond within 45 days of the date of application, deny the application.

**D. Duplicate Applications**

Applications received requesting Medicaid and/or FAMIS for individuals who already have an application recorded or *who are currently active will be denied due to duplication of request. A Notice of Action on Medicaid will be sent to the applicant when a duplicate application is denied.*

If the alien does not provide verification of his/her identity, his immigration status cannot be determined, and he must be considered an unqualified alien.

## M0220.202 SYSTEMATIC ALIEN VERIFICATION FOR ENTITLEMENTS (SAVE)

### A. SAVE

Aliens must submit documentation of immigration status before eligibility for the full package of Medicaid benefits can be determined. If the documentation provided appears valid and meets requirements, eligibility is determined based on the documentation provided AND a comparison of the documentation provided with immigration records maintained by the *United States Citizenship and Immigration Services (USCIS)*, formerly known as Immigration and Naturalization Service (INS).

The comparison is made by using the SAVE system established by Section 121 of the Immigration Reform and Control Act of 1986 (IRCA).

#### 1. Primary Verification

Primary verification is the automated method of accessing the *USCIS* data bank. SAVE regulations require that automated access be attempted prior to initiating secondary verification. There are some specific instances, however, when the agency will forego the primary verification method and initiate secondary verification (see **Secondary Verification**).

SAVE is accessed by the Alien Registration Number. The alien registration number begins with an "A" and should be displayed on the alien's *USCIS* document(s).

SAVE is accessible either by the local agency directly or through regional office contact. A primary verification document must be **initiated prior to case approval**.

Information obtained through SAVE should be compared with the original INS document. If discrepancies are noted, the secondary verification process must be initiated. No negative action may be taken on the basis of the automated verification only.

The primary verification document must be filed in the case record.

#### 2. Secondary Verification

Secondary verification is required in the following situations:

- a. The alien has an alien number but no *USCIS* document, or the alien has no alien number and no INS document.
- b. Primary verification generates the message "Institute Secondary Verification" or "No File Found."
- c. Discrepancies are revealed when comparing primary verification to the original immigration document.
- d. Immigration documents have no Alien Registration Number (A-Number).

- e. Documents contain an A-Number in the A60 000 000 or A80 000 000 series.
- f. The document presented is an *USCIS* Fee Receipt.
- g. The document presented is Form I-181 or I-94 in a foreign passport that is endorsed "Processed for I-551, Temporary Evidence of Lawful Permanent Residence," and the I-181 or I-94 is more than one year old.

When secondary verification is required, the agency will complete the top portion of a Document Verification Request (Form G-845). Appendix 2 of this subchapter contains a copy of the form.

**B. Document  
Verification  
Request (Form  
G-845)**

If the alien has filed an *USCIS* application for or received a change in status, the application for or change in status in itself is not sufficient basis for determining immigration status. Likewise, any document which raises a question of whether *USCIS* contemplates enforcing departure is not sufficient basis for determining the alien's status. In such situations, verify the alien's status with *USCIS* using the Document Verification Request (Form G-845). For an alien who entered the U.S. before 8-22-96 and whose status is adjusted to a qualified status after he entered the U.S. use the Form G-845 Supplement to request the period of continuous presence in the U.S. A copy of the G-845 Supplement is in Appendix 2a of this subchapter.

Form G-845 should be completed as fully as possible by the submitting agency. It is essential that the form contain enough information to identify the alien.

A separate form must be completed for each alien. Completely legible copies (front and back) of the alien immigration documents must be stapled to the upper left corner of Form G-845. Copies of other documents used to make the initial alien status determination such as marriage records or court documents must also be attached.

Once the requirement to obtain secondary verification is determined, the agency must initiate the request within ten work days. *A photocopy of the completed G-845 form must be filed in the record as evidence that the form has been forwarded to USCIS.* Refer to Appendix 1 for the *USCIS* mailing address appropriate to your local DSS agency.

**C. Agency Action**

While awaiting the secondary verification from *USCIS*, do not *delay, deny, reduce or terminate the individual's eligibility for Medicaid on the basis of alien status.* *If the applicant meets all other Medicaid eligibility requirements, approve the application and enroll the applicant in Medicaid.* Upon receipt of the G-845, compare the information with the case record. Timely notice must be given to the individual when Medicaid benefits are denied or reduced.

Once information has been obtained through SAVE, aliens with a permanent status are no longer subject to the SAVE process. Aliens with a temporary or conditional status are subject to SAVE at the time of application and when the temporary or conditional status expires.

and child care centers) is the school or center's records showing the child's address and relative's name and relationship. The secondary sources if the child attends school are: 1) hospital or physician's records, 2) court or public agency records, 3) contact with public housing, or 4) contact with landlord.

For pre-school age children who are not in nursery school, pre-school or a child care center, the individual's declaration of the child living with him/her will be accepted unless the worker has reason to question the accuracy of the individual's statement. Document the case record to show the verification or declaration used.

If unable to obtain verification from any source listed above, the case record must be documented to reflect all attempts made to secure verification from a primary or secondary source. The case record must also contain documentation of the evidence the worker obtained which substantiates the child's presence in the caretaker-relative's home.

#### **b. Temporary Absence From Home**

A child under age 21 who is living away from home is considered living with his/her parent(s) in the household if:

- the child is not emancipated, and
- the absence is temporary and the child intends to return to the parent's home when the purpose of the absence (such as education, rehabilitation, medical care, vacation, visit) is completed.

Children living in foster homes are NOT temporarily absent from home. They are indefinitely absent from home and are NOT living with their parents or siblings for Medicaid purposes.

*Children placed in residential treatment facilities are considered absent from their home if their stay in the residential facility has been 30 days or more. A child who is living in a residential facility is considered NOT living with his parents for Medicaid eligibility purposes as of the first day of the month in which the 30<sup>th</sup> day of residential placement occurs.*

Children in medical institutions (facilities) are temporarily absent from home if their stay in the medical facility is less than 30 consecutive days. If the stay has been, or is expected to be, 30 or more consecutive days, go to section M1410.010 to determine if the child is institutionalized in long-term care. A child who is institutionalized in a medical facility or Medicaid waiver services is NOT considered living with his or her parents for Medicaid eligibility purposes.

## **M0310.112 DISABLED**

### **A. Introduction**

The Social Security Administration (SSA) defines disability for an individual who is age 18 or older as the inability to do any substantial gainful activity (work) because of a severe, medically determinable

*physical or mental impairment which has lasted or is expected to last for a continuous period of not less than 12 continuous months, or which is expected to result in death.*

*SSA defines disability for a child under age 18 as having a medically determinable physical or mental impairment or combination of impairments that causes marked and severe functional limitations, and that can be expected to result in death or that has lasted or can be expected to last for a continuous period of not less than 12 months. However, a child cannot be found disabled if, at application, the child is performing substantial gainful activity and is not currently entitled to SSI benefits.*

*The Disability Determination Services (DDS) is a division of the Virginia Department of Rehabilitative Services (DRS). DDS is charged with making the determinations of medical eligibility for disability or blindness benefits under Social Security (SS), Supplemental Security Income (SSI), and Medicaid. DDS works in partnership with the SSA, the Department of Medical Assistance Services (DMAS), and the Department of Social Services (DSS) in processing disability and blindness claims and makes its determinations of “disabled” or “not disabled” based upon federal regulations. The same definitions of disability and blindness and the same evaluation criteria are used for all three programs.*

*The Railroad Retirement Board (RRB) makes disability determinations for railroad employees. “Total” disability determinations mean the individual is disabled for all regular work. “Occupational” disability means the individual is disabled for regular railroad occupation, but not “totally” disabled. Individuals who receive a “total” disability determination are disabled using the same criteria as the SSA.*

*The Medicaid disability definition is the same as the SS, SSI, and the Railroad Retirement (RR) total disability definition.*

## **B. Policy**

*Individuals who have been determined disabled or blind by DDS for Medicaid or for SSA, without a subsequent decision by SSA reversing the disability determination and individuals who have been determined disabled by the RRB meet the Medicaid covered group requirement of being “disabled.”*

## **C. Who Meets the Medicaid Disability Definition**

*An individual meets the Medicaid disability definition if he:*

- receives SS/SSI as a disabled individual, or RR total disability benefits; or*
- has been found to be disabled by the DDS without a subsequent decision by SSA reversing the disability decision.*

The SSI income limit reduced by one-third is used whenever an applicant/recipient lives in the home of another person throughout a month and does not pay his/her pro rata share of food and shelter expenses.

Compare total countable income to current appropriate SSI or AG income limit/payment amount as follows:

- 1) for a protected individual living with a protected or aged, blind, disabled (ABD) spouse who applies for Medicaid, compare the countable income to the current SSI payment limit for a couple. The SSI couple limit is reduced by one-third only if both members of the couple have their shelter and food provided by another person.

If income is within the appropriate limit, the individual spouse who meets the protected group criteria is eligible. If both spouses meet the protected group criteria, each is eligible as a CNNMP former SSI recipient.

The non-protected spouse's eligibility is evaluated in another covered group.

- 2) for an individual living with a spouse and/or minor dependent children who meet a families and children category or do not apply for Medicaid, count only the individual's income and the spouse's deemed income (as determined by deeming procedures in chapter M05) and compare it to the SSI limit for an individual or couple as appropriate. If all food and shelter needs are provided by the spouse or someone else, compare the countable income to the SSI limit for an individual, reduced by one-third.
- 3) for a blind or disabled child living with a parent, calculate the parent's income (as determined by deeming procedures in chapter M05) and compare the child's countable income to the SSI payment limit for an individual. If all food and shelter needs are provided by the child's parent(s) or someone else, compare the total countable income to the SSI limit for an individual, reduced by one-third.

#### 4. COLA Formula

If only the current Title II benefit amount is known OR the benefit was changed or recalculated after loss of SSI, use the formula below to figure the base Title II amount to use in determining financial eligibility. Divide the current Title II entitlement amount by the percentages given. Then follow the steps in item B.3.b. above to determine income eligibility.

Cost-of-living calculation formula:

- $$\begin{aligned}
 a. \quad & \frac{\text{Current Title II Benefit}}{1.021 \text{ (1/04 Increase)}} = \text{Benefit Before 1/04 COLA} \\
 b. \quad & \frac{\text{Benefit Before 1/04 COLA}}{1.014 \text{ (1/03 Increase)}} = \text{Benefit Before 1/03 COLA} \\
 c. \quad & \frac{\text{Benefit Before 1/03 COLA}}{1.026 \text{ (1/02 Increase)}} = \text{Benefit Before 1/02 COLA} \\
 d. \quad & \frac{\text{Benefit Before 1/02 COLA}}{1.035 \text{ (1/01 Increase)}} = \text{Benefit Before 1/01 COLA} \\
 e. \quad & \frac{\text{Benefit Before 1/01 COLA}}{1.025 \text{ (1/00 Increase)}} = \text{Benefit Before 1/00 COLA}
 \end{aligned}$$

Contact the Regional Medicaid Program Specialist for amounts for years prior to 2001.

## 5. Medicare Premiums

### a. Medicare Part B premium amounts:

1-1-04 \$66.60  
 1-1-03 \$58.70  
 1-1-02 \$54.00  
 1-1-01 \$50.00

Contact the Regional Medicaid Program Specialist for amounts for years prior to 2001.

### b. Medicare Part A premium amounts:

1-1-04 \$343.00  
 1-1-03 \$316.00  
 1-1-02 \$319.00  
 1-1-01 \$300.00

Contact the Regional Medicaid Program Specialist for amounts for years prior to 2001.

## 6. Classification

Individuals who are eligible when a cost-of-living increase is excluded are eligible as categorically needy non-money payment (CNNMP).

Individuals who are ineligible because of excess income after the cost-of-living increase(s) is excluded can only become Medicaid-eligible in another covered group. If they do not meet an F&C MI covered group, are not institutionalized, are not receiving CBC or do not have Medicare Part A, they must be determined eligible in a medically needy covered group.

**C. Determining  
Eligibility**

**1. Nonfinancial  
Eligibility**

The QSII individual must:

- meet the nonfinancial eligibility requirement in chapter M02, and
- have been eligible for and receiving Medicaid coverage *as an SSI recipient (must have met the more restrictive real property requirement)* in the month immediately preceding the first month of the 1619(b) status. The "Current Pay Status Effective Date" field on the SVES WMVE9065 screen shows the first month of the 1619(b) status.

NOTE: If you cannot determine the first month of 1619(b) status, contact SSA.

**2. Financial  
Eligibility**

***a. Resource Eligibility***

*Determine if the QSII recipient has the following real property resource(s):*

- 1) equity in non-exempt property contiguous to his/her home which exceeds \$5,000 and none of the real property exclusions in sections M1130.100, M1130.140, S1130.150, or M1130.160 apply to the property;*
- 2) an interest in undivided heir property and the equity value of his/her share when added to all other countable resources exceeds the appropriate Medicaid resource limit. (The interest in the estate must be legally available. If a partition suit is necessary to sell the interest, costs of partition and attorneys' fees may be deducted as described in M1120.215;*
- 3) ownership (equity value) of his/her former residence and the SSI recipient is in an institution for longer than 6 months. Determine if the former home is excluded under policy in section M1130.100 D;*
- 4) equity value in property owned jointly with another person, to whom the SSI recipient is not married, as tenants in common or joint tenants with the right of survivorship at common law. Determine if any of the real property exclusions in sections M1130.100, M1130.140, S1130.150, or M1130.160 apply to the property;*
- 5) other real property; determine if any of the real property exclusions in sections M1130.100, M1130.140, S1130.150, or M1130.160 apply to the property.*



*When an SSI recipient has any of the real property listed in 1) through 5) above, ALL of the recipient's resources must be verified, evaluated, and counted together to determine if the SSI recipient meets the Medicaid resource requirements.*

*Calculate resources according to the assistance unit policy in chapter M05. If current resources are NOT within the limit, the individual is NOT eligible in this covered group; he/she may be eligible as medically indigent (which has more liberal resource methods and standards).*

***b. Income Eligibility***

There are no income eligibility requirements for QSII individuals once they have been determined eligible as 1619(b).

**D. Entitlement & Enrollment**

Eligible individuals are entitled to full Medicaid coverage. They are classified as categorically needy non-money payment (CNNMP) recipients. The program designation is:

- 21 for an aged individual;
- 41 for a blind individual; *or*
- 61 for a disabled individual.

**E. Individuals Ineligible as QSII**

Individuals who are ineligible as QSII because they:

- did not receive Medicaid in the month immediately preceding the month in which SSA first determined them eligible under 1619(b) *or*
- lost 1619(b) status

must be evaluated for Medicaid eligibility in other covered groups.

NOTE: An individual who has 1619(b) status continues to meet the disabled definition. An individual who no longer has 1619(b) status may not meet the disabled definition.

**M0320.106 PROTECTED ADULT DISABLED CHILDREN**

**A. Policy**

Section 1634(c) of the Social Security Act was amended in 1987 (P.L. 99-643 §6(b)) to state that if any individual who has attained the age of 18 and is receiving benefits under Title XVI (the Supplemental Security Income program) on the basis of blindness or a disability which began before he or she attained the age of 22

- becomes entitled, on or after the effective date of this subsection (July 1, 1987), to child's insurance benefits which are payable under section 202(d) on the basis of such disability or to an increase in the amount of the child's insurance benefits which are so payable; and
- ceases to be eligible for SSI because of such child's insurance benefits under the title or because of the increase in such child's insurance benefits,

shall be treated as receiving SSI benefits for Medicaid eligibility purposes so long as he/she would be eligible for SSI in the absence of such child's insurance benefits or such increase.

#### **B. Nonfinancial Eligibility**

A protected adult disabled child is one who:

- meets the nonfinancial eligibility requirements in chapter M02;
- has reached the age of 18 years and receives SSI payments on the basis of blindness or a disability which began before he or she reached the age of 22 years;
- on or after July 1, 1987, becomes entitled to SSA Title II disabled child's insurance benefits on the basis of such disability, or receives an increase in Title II disabled child's insurance benefits;
- becomes ineligible for SSI on or after July 1, 1987 because of the receipt of, or increase in, Title II disabled child's benefits;
- has resources within the current Medicaid resource limit; and
- has income which, in the absence of the Title II disabled child's benefit, or in the absence of the increase in such benefit, is within the current SSI income limit.

If the individual is not enrolled in Medicare Part A under Section 1818A as of the month he/she meets the Medicaid eligibility requirements, the individual's entitlement to Medicaid cannot begin until the first day of the month in which his Medicare Part A enrollment under Section 1818A is effective.

The eligible QDWI will only receive Medicaid payment of his/her Medicare Part A premium through the Medicaid Buy-In Agreement with SSA. **The QDWI will not receive a Medicaid card.**

#### **E. Enrollment**

##### **1. Program Designation**

The PD (program designation)) for all QDWIs is "55."

##### **2. Recipient's PD Changes To QDWI**

An enrolled recipient's PD cannot be changed to PD "55" using a "change" transaction in the MMIS. If a Medicaid recipient becomes ineligible for full-coverage Medicaid, but is eligible as a QDWI, the agency must send an advance notice of proposed action to the recipient because services are being reduced. The notice must specify that he will remain eligible only for payment of Medicare Part A premiums as a QDWI.

Cancel the recipient's full coverage effective the last day of the month, using cancel reason "07." Reinstatement the recipient's coverage as QDWI with the begin date as the first day of the month following the cancellation effective date. Program designation is "55."

##### **3. QDWI's PD Changes To Full Coverage PD**

When an enrolled QDWI becomes eligible in another classification and covered group which has full Medicaid coverage, except when he/she meets a spenddown, e.g., he/she is no longer able to work and starts to receive SSA and SSI disability benefits:

- cancel the QDWI coverage effective the last day of the month immediately prior to the month in which he/she became eligible in the full coverage classification and covered group, using cancel reason "24;"
- reinstate the recipient's coverage with the begin date as the first day of the month in which he/she became eligible in the full coverage covered group, with the appropriate full coverage PD.

##### **4. Spenddown Status**

Eligible QDWIs who meet an MN covered group and who have resources that are within the lower MN resource limits are also placed on two 6-month medically needy spenddowns.

##### **5. QDWI Meets Spenddown**

When a QDWI meets a spenddown, cancel his PD "55" coverage effective the date before spenddown was met using cancel reason "24." *Reinstate coverage as medically needy beginning the day the spenddown was met and ending the last day of the spenddown budget period.*

The PD is NOT dual-eligible:

- 18 for an aged MN individual NOT eligible as QMB;
- 38 for a blind MN individual NOT eligible as QMB;
- 58 for a disabled MN individual NOT eligible as QMB.

**6. Spenddown  
Period Ends**

After the spenddown period ends, reinstate the QDWI-only coverage using the PD “55.”

The begin date of the reinstated PD “55” coverage is the first day of the month following the end of the spenddown period, and the application date is the date of the original application used to determine the initial QDWI eligibility.

**7. QDWI Enters  
Long-term  
Care**

The enrollment of a QDWI who is admitted to long-term care and who becomes eligible for Medicaid in another classification and covered group is handled like a QDWI who meets a spenddown. Cancel the QDWI-only coverage effective the last day of the month before the admission to long-term care, reason “24.” Reinstall the coverage with the begin date as the first day of the month of admission to long-term care.

**M0320.210 ABD WITH INCOME  $\leq$  80% FEDERAL POVERTY LIMIT (FPL)**

**A. Policy**

Section 1902(m) of the Social Security Act allows a State to provide full Medicaid benefits to the categorically needy covered group of aged, blind and disabled individuals whose income is less than or equal to a percentage of the federal poverty limit (FPL).

The 2000 Appropriations Act mandated that effective July 1, 2001, the State Plan for Medical Assistance be amended to add the covered group of aged, blind and disabled individuals with income less than or equal to 80% FPL.

*Eligibility in the ABD 80% FPL covered group is limited to those ABD individuals who do not meet the requirements for any other full benefit Medicaid covered group. ABD individuals who meet the requirements for the 300% SSI covered groups (see M0320.203 and 204) or are medically needy without a spenddown (see M0330) are to be enrolled in these groups and not in the ABD 80% FPL covered group. An eligible individual's resources must be within the SSI resource limits.*

**B. Nonfinancial  
Eligibility**

An individual in this covered group must meet the nonfinancial requirements in chapter M02:

- aged, blind, or disabled definition in subchapter M0310;
- citizenship/alien status;
- Virginia residency;
- Social Security number provision/application requirements;
- assignment of rights to medical benefits requirements;
- application for other benefits; and
- institutional status.

## M0520.000 FAMILIES & CHILDREN (F&C) FAMILY/BUDGET UNIT

### M0520.001 OVERVIEW

#### A. Introduction

This subchapter contains the policy and procedures for determining the assistance unit for an individual or family who meets a Families & Children (F&C) covered group. For F&C financial eligibility determination purposes, the assistance unit is called the “family/budget” unit. A household is divided into one or more family units.

The family unit’s financial eligibility is determined first. If the family unit has resources or income that *cannot be verified or that exceeds the limit for the individual’s* covered group, the family unit is divided into “budget” units if certain requirements are met.

#### B. Policy

Medicaid law prohibits the consideration of resources and income of any person other than a spouse or parent in the final Medicaid eligibility determination. Resources and income CANNOT be counted

- from a stepparent to a stepchild;
- from a sibling to a sibling;
- from a child to a parent;
- from a spouse or parent living apart from the individual, unless it is a voluntary or court-ordered or DCSE-ordered contribution (exception for individuals in long-term care);
- from an alien sponsor to the alien.

The family unit will include any child(ren) under age 21 living in the home for whom a unit member is legally responsible regardless of whether or not the child(ren) meet(s) a covered group, unless the child is specifically excluded.

##### 1. Member In One Unit

An applicant/recipient can be a member of only one family unit or one budget unit at a time.

##### 2. May Exclude A Child

The applicant can choose to exclude any child(ren) from the family unit for any reason. If the parent wants to exclude a child who has been listed on the application, the request for exclusion must be in writing. None of the excluded child's needs are considered, and none of his income or resources are counted or deemed available to the unit. The advantages and disadvantages of the choice must be explained to the applicant or recipient.

##### 3. Child Under 21 Living Away From Home

A child under age 21 who is living away from home is considered living with his/her parent(s) in the household for family unit composition purposes if:

- the child is not emancipated, and
- the absence is temporary and the child intends to return to the parent's home when the purpose of the absence (such as education, rehabilitation, medical care, vacation, visit) is completed.

Children living in foster homes institutions are NOT temporarily absent from home. They are indefinitely absent from home and are NOT living with their parents or siblings for Medicaid purposes.

*Children placed in residential treatment facilities are considered absent from their home if their stay in the residential facility has been 30 days or more. A child who is placed in a residential facility is considered NOT living with his parents for Medicaid eligibility purposes as of the first day of the month in which the 30<sup>th</sup> day of residential placement occurs. Long-term care rules do not apply to these children.*

Children in medical institutions (facilities) are temporarily absent from home if their stay in the medical facility is less than 30 consecutive days. If the stay has been, or is expected to be, 30 or more consecutive days, go to section M1410.010 to determine if the child is institutionalized in long-term care. A child who is institutionalized in a medical facility or Medicaid waiver services is NOT considered living with his or her parents for Medicaid eligibility purposes.

### C. Procedure

This section contains an overview of the F&C family unit and budget unit rules. The detailed policy and procedures are contained in the following sections:

- M0520.010 Definitions;
- M0520.100 Family Unit Rules;
- M0520.200 Budget Unit Rules;
- M0520.300 Deeming From Spouse;
- M0520.400 Deeming From Parent;
- M0520.500 Changes In Status;
- M0520.600 Pregnant Woman Budget Unit;
- M0520.700 Individual Under Age 21 Family Unit.

## M0520.010 DEFINITIONS

### A. Introduction

This section contains definitions of the terms used in the F&C family/budget unit policy and procedures.

### B. Acknowledged Father

A male individual who is not married to the mother is an acknowledged father if any of the following exist:

- the man has been found by a court to be the child's father;
- the man has admitted paternity either before a court, or voluntarily in writing, under oath;
- the man has been found by a blood test to be the child's father;
- the man's name appears on the child's official birth certificate;
- the child has been placed by a court with the man or a relative of the man on the basis that he is the child's father.

Children in medical institutions (facilities) are temporarily absent from home if their stay in the medical facility is less than 30 consecutive days. If the stay has been, or is expected to be, 30 or more consecutive days, go to section M1410.010 to determine if the child is institutionalized in long-term care. A child who is institutionalized in a medical facility or Medicaid waiver services is NOT considered living with his parents for Medicaid eligibility purposes.

*Children placed in residential treatment facilities are considered absent from their home if their stay in the residential facility has been 30 days or more. A child who is placed in a residential facility is considered NOT living with his parents for Medicaid eligibility purposes as of the first day of the month in which the 30<sup>th</sup> day of residential placement occurs. Long-term care rules do not apply to these children.*

**4. Pregnant Woman**

An individual who meets the pregnant woman definition is counted as at least **two persons** when her eligibility is being determined in the MI Pregnant Woman or MN Pregnant Woman covered group. The unborn child (or children, if medical documentation verifies more than one fetus) must be included in the unit with the pregnant woman when determining her eligibility. A separate calculation is required for the other family unit members who do not meet a pregnant woman covered group. This calculation does NOT include the unborn child(ren) as part of the family unit and/or budget unit (BU).

When an individual is pregnant but her eligibility is determined in a covered group other than MI or MN Pregnant Woman, such as blind, disabled or Low Income Families with Children (LIFC), the pregnant woman is counted as just one person.

**5. Cohabitant**

A cohabitant is not the child(ren)'s parent and is not legally responsible for anyone in the family unit. Therefore, the cohabitant is not included in the family unit. Do not count a cohabitant's income or resources.

**C. Examples**

**1. Household With Excluded Child**

**EXAMPLE #1:** Household listed on application consists of applicant, her disabled spouse, her 15-year old son, and husband's 20-year old daughter. The 20-year old daughter is employed full-time. Medicaid is requested for applicant, her spouse, and her son. She specifies in writing that she wishes to exclude her husband's 20-year old daughter. The family unit consists of:

- the applicant
- her husband, and
- her 15-year old son.

The family unit's income is determined using the F&C income policy and procedures.

**2. Household  
With  
Acknowledged  
Father**

**EXAMPLE #2:** *Household listed on the Medicaid application consists of pregnant woman applicant, her 5-year old son and her boyfriend, who is the acknowledged father of the 5-year old. They all request Medicaid.*

*The family unit for the Medicaid eligibility determination for the 5-year old child, and the acknowledged father consists of:*

- *the woman,*
- *the 5-year old child and*
- *the child's acknowledged father.*

*The family unit for the Medicaid eligibility determination for the pregnant woman consists of:*

- *the pregnant woman,*
- *her unborn child,*
- *the 5-year old child, and*
- *the child's acknowledged father.*

*The family unit's income is determined using the F&C income policy and procedures.*

## **M0520.101 MULTIPLE FAMILY UNITS**

**A. Policy**

Multiple family units exist in a household in the following situations:

**1. Non-parent  
Caretaker**

When the individual is applying for Medicaid as a non-parent caretaker of a deprived dependent child, multiple family units exist.

**2. EWB  
(Essential to  
the Well-  
Being)**

When the individual is applying for Medicaid as an individual who is EWB to family with a deprived dependent child, multiple family units exist.

**3. Child--No  
Responsible  
Relative In  
Home**

When the individual applying is a child under age 21 but has no responsible relative living in the household and is not a sibling of another child(ren) in the household, multiple family units exist.

**4. Adult--No  
Responsible  
Relative In  
Home**

When the individual applying is age 21 or older and is not legally responsible for the other applicant(s) in the household, multiple family units exist.

**5. Foster Care  
Child**

When the individual applying is a foster care child whose parent(s) live in the household and who is placed in his/her home for a trial visit (see M0520.701 below), multiple family units exist.

**6. Siblings**

Siblings under age 21 are included in the same family unit.



## Deeming Allocations

The deeming policy determines how much of a legally responsible relative's income is deemed to the applicant/recipient. The allocation amount increases automatically whenever the SSI payment limit increases.

### NBD (Non-blind/disabled) Child Allocation

The NBD child allocation is equal to the difference between the SSI payment for two persons and the SSI payment for one person.

SSI payment for couple - SSI payment for one person = NBD child allocation

$$\$846 - 564 = \$282$$

### Parental Living Allowance

The living allowance for one parent living with the child is the SSI payment for one person.

SSI payment for one person = \$564

The living allowance for both parents living with the child is the SSI payment for a couple.

SSI payment for both parents = \$846

### Deeming Standard

The NABD (non-age/blind/disabled) spouse deeming standard is the difference between the SSI payment for two persons and the SSI payment for one person.

SSI payment for couple - SSI payment for one person = deeming standard

$$\$846 - 564 = \$282$$

**2. Unearned Income**

Unearned income is all income that is not earned income. Some types of *unearned* income are:

- annuities, pensions, and other periodic payments;
- alimony and support payments;
- dividends, interest, and royalties; or
- rents.

**C. References**

- Definition of net countable income, M0710.003
- Earned income, M0720
- Unearned income, M0730

**M0710.030 WHEN INCOME IS COUNTED**

**A. Policy Principles**

For applications and reapplications, the income generally to be counted is the income verified for the calendar month prior to the month of application or the most current equivalent (last 4 weekly pays, last 2 bi-weekly pays, or last 2 semi-monthly pays). When evaluating eligibility for a retroactive period, income eligibility is based on income actually received each month in the retroactive period.

For redeterminations, the income generally to be counted is the income verified for the month prior to the month of review or the most current equivalent.

**B. Exceptions to Policy Principles**

**1. Payment Not Received In Normal Month of Receipt**

FU/BUs receiving monthly or semi-monthly income, such as state or federal payments or semi-monthly pay checks, must have the income assigned to the normal month of receipt even if mailing cycles, weekends or holidays cause the income to be received in a different month.

**EXAMPLE #1:** The applicant/recipient is employed and is paid semi-monthly on the first and sixteenth. Because June 1 falls on a Saturday, the client receives her June 1 paycheck on May 31. The Eligibility Worker will count the paycheck received May 31 as income for June.

**2. Self-Employment or Sale of Livestock or Cash Crops**

Profit from the sale of livestock or cash crops, such as tobacco or peanuts, or from small businesses, such as but not limited to, vending stands, home beauty shops, or small grocery stores, is prorated on an annual basis or over the number of months in which the income is earned, whichever is appropriate. Federal farm subsidies are prorated over a 12-month period.

**3. Contract Income**

Guaranteed salaries paid under contract are prorated over the period of the contract even though the employee elects to receive such payments in

fewer months than are covered by the contract. When the contract earnings will be received monthly over a period longer than that of the contract, the earnings must be prorated over the number of months the income is anticipated to be received.

**C. References**

Contract Income, M0720.400

Income From Self-Employment, M0720.200

**M0710.610 HOW TO ESTIMATE INCOME****A. Monthly Estimates**

Generally, estimate future income on a monthly basis.

**1. Anticipated Income**

Anticipated income means any income the applicant/recipient and local agency are reasonably certain will be received during the month. If the amount of income or when it will be received is uncertain, that portion of the FU/BU's income that is uncertain is not counted by the local agency. Reasonably certain means that the following information is known:

- who the income will come from,
- in what month it will be received, and
- how much it will be (i.e., rate, frequency and payment cycle).

**2. Fluctuating Income**

When income fluctuates, use the previous number of months' actual receipts that will provide an accurate indication of the individual's future income situation.

**3. Income Expected Less Than Once a Month**

Determine the specific month(s) of receipt and use the amount(s) estimated for the appropriate month(s).

**4. Converting to Monthly Totals**

To estimate income for an income evaluation, convert to a monthly amount:

- multiply average weekly amounts by 4.3
- multiply average bi-weekly amounts by 2.15
- multiply semi-monthly amounts by 2

**5. Partial Month Income**

If the FU/BU will receive less than a full month's pay, use the exact monthly figure or an average per pay period times the actual number of pays. If actual income is used in any given calculation, adjust the figure for subsequent months if the actual income varies.

<b>MEDICALLY INDIGENT CHILD UNDER AGE 19 (<i>FAMIS PLUS</i>)</b> <b>ALL LOCALITIES</b> <b><i>FEDERAL POVERTY LEVEL (FPL) INCOME LIMITS</i></b> <b>EFFECTIVE 2-13-04</b>		
<u># of Persons in Family/Budget Unit</u>	<u>100% FPL Monthly Limit</u>	<u>133% FPL Monthly Limit</u>
1	\$776	\$1,032
2	1,041	1,385
3	1,306	1,737
4	1,571	2,090
5	1,836	2,442
6	2,101	2,795
7	2,366	3,147
8	2,631	3,500
each add'l person add	265	353

MI Child under age 6 with income less than or equal to 100% FPL –PD 91

MI Child age 6 to 19 with income less than or equal to 100% FPL – PD 92

MI Child under age 6 with income greater than 100% FPL and less than or equal to 133% FPL – PD 90

**Insured** MI Child age 6 to 19 with income greater than 100% FPL and less than or equal to 133% FPL –PD 92

**Uninsured** MI Child age 6 to 19 with income greater than 100% FPL and less than or equal to 133% FPL PD 94

<b>PREGNANT WOMAN 133% FPL INCOME LIMITS ALL LOCALITIES EFFECTIVE 2-13-04</b>	
<u># of Persons in Family/Budget Unit</u>	<u>Monthly Limit</u>
1	\$1,032
2	1,385
3	1,737
4	2,090
5	2,442
6	2,795
7	3,147
8	3,500
each add'l person add	353

Pregnant Woman with income less than or equal to 133% FPL – PD 91

**185% of FEDERAL POVERTY LIMITS  
TWELVE MONTH EXTENDED MEDICAID  
INCOME LIMITS  
ALL LOCALITIES  
EFFECTIVE 2-13-04**

<u># of Persons in Family/Budget Unit</u>	<u>Monthly Limit</u>
1	\$1,436
2	1,926
3	2,416
4	2,907
5	3,397
6	3,887
7	4,377
8	4,868
each add'l person add	491

## GENERAL

### M0810.001 INCOME AND ELIGIBILITY

#### A. Introduction

The following sections explain how to treat income in the Medicaid program. This chapter explains how we count income.

#### B. Policy Principles

##### 1. Who is Eligible

An individual is eligible for Medicaid if the person:

- meets a category/classification; and
- meets the nonfinancial requirements; and
- meets the classification's resource limits; and
- meets the classification's income limits.

##### 2. General Income Rules

- Count income on a monthly basis.
- Not all income counts in determining eligibility.
- If an individual's countable income exceeds a classification's monthly limit, a medically needy spenddown may be established, if appropriate.

### M0810.002 INCOME LIMITS

#### A. Income Limits

The Medicaid classification determines which income limit to use to determine eligibility.

##### 1. Categorically Needy

Supplemental Security Income (SSI) and State Supplement (Auxiliary Grant) recipient's money payments meet the income eligibility criteria in the ABD Categorically Needy classification.

##### 2. Categorically Needy Non-Money Payment-Protected Cases Only

<ul style="list-style-type: none"><li>• Categorically-Needy Non-Money Payment Protected Covered Groups Which Use SSI Income Limits</li></ul>	
Family Unit Size	Monthly Amount
1	\$564
2	846
<ul style="list-style-type: none"><li>• For individual or couple whose total food and shelter needs are contributed to him or them</li></ul>	
Family Unit Size	Monthly Amount
1	\$375.62
2	563.94

**3. Categorically  
Needy-Non  
Money  
Payment  
(CNNMP) -  
300% of SSI**

For the covered groups that use the 300% of SSI income limit, all income is counted (even excluded income) when screening at 300% of SSI. Do not count any monies which are defined as “what is not income” in S0815.000.

<ul style="list-style-type: none"> <li>Categorically Needy-Non Money Payment 300% of SSI</li> </ul>	
Family Size Unit 1	Monthly Amount \$1,692

**4. Medically  
Needy**

a. Group I		
Family Unit Size	Semi-annual	Monthly
1	\$ 1,380.48	\$ 230.08
2	1,758.04	293.00
b. Group II		
Family Unit Size	Semi-annual	Monthly
1	\$ 1,592.86	\$ 265.47
2	1,961.71	326.95
c. Group III		
Family Unit Size	Semi-annual	Monthly
1	\$ 2,070.72	\$ 345.12
2	2,496.77	416.12

**5. ABD  
Medically  
Indigent**

**For:  
ABD 80%  
FPL, QMB,  
SLMB, & QI  
without Social  
Security (SS)  
and QDWI,  
effective  
2/13/04; and  
ABD 80%  
FPL, QMB,  
SLMB, & QI  
with SS,  
effective 4/1/04**

ABD 80% FPL	Annual	Monthly
1	\$ 7,448	\$ 621
2	9,992	833
QMB 100% FPL	Annual	Monthly
1	\$ 9,310	\$ 776
2	12,490	1,041
SLMB 120% of FPL	Annual	Monthly
1	\$11,172	\$ 931
2	14,988	1,249
QI 135% FPL	Annual	Monthly
1	\$12,569	\$1,048
2	16,862	1,406
QDWI 200% of FPL	Annual	Monthly
1	\$18,620	\$1,552
2	24,980	2,082



**C. Procedure**

**1. Verification**

- a. Verify these payments by examining documents in the individual's possession which reflect:
  - the amount of the payment,
  - the date(s) received, and
  - the frequency of payment, if appropriate.
- b. If the individual has no such evidence in his possession, contact the source of the payment.
- c. If verification cannot be obtained by the above means, accept any evidence permitted by either S0820.130 A. or S0820.220.

**2. Assumption**

Assume that any honoraria received is **in consideration of services rendered**, absent evidence to the contrary. Evidence to the contrary would include a statement or document indicating that part or all of the honoraria is for something other than services rendered (e.g., travel expenses or lodging).

**3. Expenses of Obtaining Income**

DO NOT DEDUCT any expenses of obtaining income from royalties or honoraria that are earned income. (Such expenses are deductible from royalties/honoraria that are unearned income.)

**4. Documentation**

Document the file by including copies of documents or indicating in the file information provided by the payment source concerning the amount and, if appropriate, frequency of payment.

**D. References**

- Royalties as unearned income, S0830.510.
- To determine deductible IRWE/BWE, see S0820.535 - .565.

## EARNED INCOME EXCLUSIONS

### S0820.500 GENERAL

#### A. Policy

1. **General**

The source and amount of all earned income must be determined, but not all earned income counts when determining Medicaid eligibility.
2. **Other Federal Laws**

First, income is excluded as authorized by other Federal laws.
3. **Other Earned Income**

Then, other income exclusions are applied, in the following order, to the rest of earned income in the month:

  - a. Federal earned income tax credit payments
  - b. Up to \$10 of earned income in a month if it is infrequent or irregular
  - c. Up to \$1,370 per month, but not more than \$5,520 in a calendar year, of the earned income of a blind or disabled student child
  - d. Any portion of the \$20 monthly general income exclusion which has not been excluded from unearned income in that same month
  - e. \$65 of earned income in a month
  - f. Earned income of disabled individuals used to pay impairment-related work expenses
  - g. One-half of remaining earned income in a month
  - h. Earned income of blind individuals used to meet work expenses
  - i. Any earned income used to fulfill an approved plan to achieve self-support.
4. **Unused Exclusion**

Earned income is never reduced below zero. Any unused earned income exclusion is never applied to unearned income.

Any unused portion of a monthly exclusion cannot be carried over for use in subsequent months.
5. **Couples**

The \$20 general and \$65 earned income exclusions are applied only once to a couple, even when both members (whether eligible or ineligible) have income, since the couple's earned income is combined in determining Medicaid eligibility.

#### B. References

For exclusions which apply to both earned and unearned income, see:

- S0810.410 for infrequent/irregular income
- S0810.420 \$20 general exclusion
- S0810.430 amount to fulfill a plan for achieving self-support

For exclusions applicable only to earned income, see S0820.510 - S0820.570.

## S0820.510 STUDENT CHILD EARNED INCOME EXCLUSION

### A. Policy

- 1. General**

For a blind or disabled child who is a student regularly attending school, earned income is excluded under this provision, limited to the maximum amounts shown below.

For Months	Up to per month	But not more than in a calendar year
In calendar years before 2001	\$ 400	\$1,620
In calendar year 2001	\$1,290	\$5,200
In calendar year 2002	\$1,320	\$5,340
In calendar year 2003	\$1,340	\$5,410
<i>In calendar year 2004</i>	<i>\$1,370</i>	<i>\$5,520</i>
- 2. Qualifying for the Exclusion**

The individual must be:

  - a child under age 22; and
  - a student regularly attending school.
- 3. Earnings Received Prior to Month of Eligibility**

Earnings received prior to the month of eligibility do not count toward the yearly limit.
- 4. Future Increases**

The monthly and yearly limits will be adjusted annually based on increases in the cost of living index. Under this calculation, these amounts will never be lower than the previous year's amounts. However, there may be years when no increases result from the calculation.

### B. Procedure

- 1. Application of the Exclusion**

Apply the exclusion:

  - consecutively to months in which there is earned income until the exclusion is exhausted or the individual is no longer a child; and
  - only to a student child's own income.
- 2. School Attendance and Earnings**

Develop the following factors and record them:

  - whether the child was regularly attending school in at least 1 month of the current calendar quarter, or expects to attend school for at least 1 month in the next calendar quarter, and
  - the amount of the child's earned income (including payments from Neighborhood Youth corps, Work-Study, and similar programs).

Verify wages of a student child even if they are alleged to be \$65 or less per month.

**C. References**

- Grants, scholarships and fellowships, S0830.455.
- Educational assistance with Federal funds involved, S0830.460.

**D. Example**  
*(Using April 2002 Figures)*

Jim Thayer, a student child, starts working in June at a local hardware store. He had no prior earnings during the year, and he has no unearned income. Jim earns \$1,600 a month in June, July and August. In September, when he returns to school, Jim continues working part-time. He earns \$800 a month in September and October. Jim's countable income computation for June through October is as follows:

June, July and August

\$1600.00	gross earnings
<u>- 1320.00</u>	student child exclusion
\$ 280.00	
<u>- 20.00</u>	general income exclusion
\$ 260.00	
<u>- 65.00</u>	earned income exclusion
\$ 195.00	
<u>- 97.50</u>	one-half remainder
\$ 97.50	countable income

Jim has used up \$3,960 of his \$5,340 yearly student child earned income exclusion (\$1,320 in each of the three months).

September

\$800.00	gross earnings
<u>- 800.00</u>	student child exclusion
0	countable income

Jim has now used up \$4,760 of his \$5,340 yearly student child earned income exclusion.

October

\$800.00	gross earnings
<u>- 580.00</u>	student child exclusion <i>remaining (\$5,340-\$4,760=\$580)</i>
\$220.00	
<u>- 20.00</u>	general income exclusion
\$200.00	
<u>- 65.00</u>	earned income exclusion
\$135.00	
<u>- 67.50</u>	one-half remainder
\$ 67.50	countable income

Jim has exhausted his entire \$5,340 yearly student child earned income exclusion. The exclusion cannot be applied to any additional earnings during the calendar year.

- for recipients, the first day of the month **following** the month in which the asset was transferred.

However, if the individual meets all Medicaid eligibility requirements, the individual is eligible for Medicaid payment of all other covered services.

Penalty periods that are imposed cannot overlap or run concurrently. The total cumulative uncompensated value of the assets transferred is used to determine the length of the penalty period.

The penalty period continues (it does not change or stop) when an institutionalized individual is discharged from long-term care. If the individual is re-admitted to LTC and the penalty period has not ended, Medicaid payment for LTC services will again be denied for the remainder of the penalty period.

#### B. Penalty Date

For applicants who are applying for Medicaid, the penalty date is **the first day of the month in which the asset transfer occurred** provided that date does not occur during an existing penalty period.

For recipients of Medicaid who transfer an asset while receiving Medicaid, the penalty date is **the first day of the month FOLLOWING the month** in which the asset transfer occurred, provided that date does not occur during an existing penalty period.

#### C. Penalty Period Calculation

The penalty period is the number of months calculated by taking the uncompensated value of the assets transferred on or after the look-back date, divided by the average monthly cost of nursing facility services to a private patient **at the time of application for Medicaid**. Beginning 10-1-97, the average cost differs for individuals in Northern Region localities (see Appendix 1 to this subchapter for the list of localities in the Northern Region). The average cost is determined based on the locality in which the **individual is physically located at the time of application for Medicaid**.

See the chart below for the average private nursing facility cost for Northern Region localities and all other Virginia localities.

#### D. Average Monthly Private Nursing Facility Cost

<u>Application Date</u>	<u>Average Monthly Private Nursing Facility Cost*</u>	
	<u>Northern Region</u>	<u>All Other Localities</u>
10-1-96 to 10-1-97	\$2,564	\$2,564
10-1-97 to 12-31-99	\$3,315	\$2,585
01-01-00 to 12-31-00	\$3,275	\$2,596
01-01-01 to 12-31-01	\$4,502	\$3,376
01-01-02 to 12-31-03	\$4,684	\$3,517
01-01-04 and after	\$5,403	\$4,060

*\*Figures provided by Virginia Health Information.*

*Contact a Medicaid Consultant for amounts prior to October 1, 1996.*

**E. One Transfer**

1. Determine the penalty period:
  - divide the uncompensated value by the average monthly private pay nursing facility cost at the time the individual applied for Medicaid;
  - round the result down;
  - the result is the number of months in the penalty period.
2. Determine the penalty date.
3. Beginning with the penalty date, count the number of months in the penalty period to the end of the period.
4. The last day of the last month in the penalty period is the end date of the penalty period.

**EXAMPLE #14:** Mr. D. a 67 year old widower who lives in his own home applies for Medicaid on May 2, 1993. He is found eligible for retroactive and ongoing Medicaid. He remains eligible for Medicaid and remains living in his home.

On September 20, 1996, Mr. D. is admitted to a nursing facility. Upon reviewing his eligibility, the agency finds that he transferred his home to his nephew on August 16, 1994, after he had been in the hospital for a few days and possible nursing facility placement had been discussed. His home was assessed at \$85,000 in August 1994. He received no compensation. The agency determines the transfer occurred within the 36 months prior to 9-20-96, the date Mr. D. was both institutionalized and a Medicaid recipient. The look-back date is September 1, 1993; the look-back period is September 20, 1993 through September 20, 1996. The transfer occurred after the look-back date. The agency evaluates the transfer and determines that the transfer affects eligibility because it does not meet any of the criteria in section M1450.501 and 502.

The agency must impose a penalty period. The uncompensated property value is \$85,000.

$$\begin{array}{r} \$85,000 \text{ assessed value} \\ \div \underline{2,230} \text{ avg. cost NF care at time of his 5-2-93 application} \\ 38.11 \text{ rounded down to 38} \end{array}$$

The penalty period based on the uncompensated value is 38 months. Because Mr. D is a recipient, the penalty date is September 1, 1994. The penalty period begins September 1, 1994 and ends October 31, 1997.

**10. Old Bills**

Old bills are unpaid medical, dental, or remedial care expenses which:

- were incurred prior to the Medicaid application month and the application's retroactive period,
- were not fully deducted from (counted in) any previous spenddown budget period where the spenddown was met, and
- remain a liability to the individual.

EXCEPTION: Bills paid by a state or local program and which meet the definition of “old bills” are treated as old bills even though they are not the individual’s liability.

**11. Projected Expenses**

Expenses for services that have not yet been incurred but are reasonably expected to be incurred are projected expenses.

**12. Spenddown Liability**

The spenddown liability is the amount by which the individual’s countable income exceeds the MNIL for the budget period.

**M1460.200 DETERMINATION OF COVERED GROUP****A. Overview**

An individual in LTC who meets the Medicaid non-financial eligibility requirements in M1410.010 must also meet the requirements of at least one covered group in order to be eligible for Medicaid and Medicaid payment of LTC services.

**1. Covered Groups Eligible for Long Term Care Services**

The covered groups whose benefit packages include long-term care services are the following groups:

- a. All categorically needy (CN) covered groups.
- b. All categorically needy non-money payment (CNNMP) covered groups.
- c. ABD with income  $\leq$  80% FPL (ABD 80% FPL).
- d. All medically indigent (MI) Families & Children (F&C) covered groups:
  - pregnant women and newborns under age 1 year,
  - children under age 19.
- e. All medically needy (MN) covered groups; however, Medicaid will not pay for the following services for MN individuals:
  - ICF-MR services,
  - IMD services,
  - MR Waiver services, and
  - DD Waiver services.

**2. Applicants  
Who Do Not  
Receive Cash  
Assistance**

**a. Child Under Age 19**

If the applicant is a child under age 19, first determine the child's eligibility as an MI child, using the covered group policy in M0320 and the financial eligibility policy in chapters M05, M06 and M07. If not eligible as MI, determine the child's eligibility in the CNNMP 300% SSI group, using the covered group policy in subchapter M0320 and the financial eligibility policy and procedures in this subchapter.

If the child's resources or income exceed the limits for the 300% SSI group, determine the child's eligibility in an MN covered group (subchapter M0330).

NOTE: A child who is age 18, 19 or 20 meets an MN covered group if he is blind, disabled, pregnant, in foster care, adoption assistance, or institutionalized in a nursing facility. An individual age 21 or older, must meet the pregnant, aged, blind or disabled definition in order to meet an MN covered group.

**b. Individual Age 19 or Older**

If the applicant is an individual age 19 or older, determine the individual's eligibility in the ABD or F&C covered group depending on which definition the individual meets, using the financial eligibility policy and procedures in this subchapter.

For ABD individuals, determine the individual's eligibility in the *300% SSI* covered group. If not eligible in the *300% SSI* covered group, determine the individual's eligibility in the *ABD 80% FPL* covered group. If not eligible in the *ABD 80% FPL* covered group, determine the individual's eligibility in the MN (see M0330) and the *limited benefit* ABD MI (see M0320) covered groups.

For F&C individuals, first determine the individual's eligibility in the CNNMP 300% SSI group. If the individual's income exceeds the limits for 300% SSI covered group, determine the individual's eligibility in an MN covered group (see M0330).

**B. Relation to Income  
Limits**

Determination of the appropriate covered group must be made prior to determination of income because the income limits are determined by the covered group:

**1. 300% SSI**

The ABD income policy in chapter S08 is used to determine income for all individuals (ABD and F&C) in the 300% SSI group. The items found in "Countable Income for the 300% SSI Group", section M1460.611 ARE counted in determining income eligibility for long-term care. The income items listed in "What Is Not Income", section M1460.610 are not counted for the 300% SSI groups (ABD and F&C).

**2. ABD 80% FPL**

The ABD income policy in chapter S08 is used to determine countable income for the ABD 80% FPL covered group. The income items listed in "What Is Not Income", Section M1460.610 and in "Countable Income for the 300% SSI Group", Section M1460.611 are NOT counted as income in determining



income eligibility for the ABD 80% FPL covered group.

**3. ABD MN Groups**

The ABD income policy in chapter S08 is used to determine countable income for the ABD MN covered groups. However, the income items listed in "What Is Not Income", Section M1460.610 and in "Countable Income for the 300% SSI Group", Section M1460.611 are NOT counted as income in determining income eligibility for ABD MN groups.

**4. F&C MI and MN Groups**

The F&C income policy in chapter M07 is used to determine countable income for individuals in F&C MI and MN covered groups. However, the income items listed in "What Is Not Income", section M1460.610 and "Countable Income for the 300% SSI Group", Section M1460.611 are NOT counted when determining income eligibility for F&C MI and MN groups.

**C. Ongoing Recipient Enters LTC**

**1. Cash Assistance Recipients**

Recipients who are already enrolled in Medicaid when they enter Medicaid long-term care and who receive cash assistance payments must have their eligibility reviewed. They already meet a covered group but they must also meet the asset transfer, resource and financial eligibility requirements in order for Medicaid to cover the cost of long-term care services.

**2. Other Recipients**

Recipients who do not receive cash assistance but who are already enrolled in Medicaid when they enter long-term care in a medical facility **must have their eligibility redetermined**. They must meet a covered group and they must meet the asset transfer, resource, and financial eligibility requirements in order for Medicaid to cover the LTC services cost.

Review the asset transfer policy in subchapter M1450 with the recipient if he has transferred assets. If the recipient is admitted to a nursing facility, or moves from his home to receive Medicaid CBC in another person's home, review asset transfer, home property and other resource requirements to determine if the individual remains eligible for Medicaid.

A married recipient who enters LTC must have resource and income eligibility redetermined using the rules in subchapter M1480, if his spouse is a community spouse.

**D. Covered Groups**

The financial eligibility rules for each covered group are contained in the following sections:

**1. SSI Recipients**

SSI recipients' financial eligibility requirements are in section M1460.201 below.

**2. Other CN Groups**

Other categorically needy groups are listed in section M1460.210 below.

- |                        |  |
|------------------------|--|
| 3. <b>CNNMP Groups</b> | CNNMP groups are listed in section M1460.220 below   |
| 4. <b>ABD 80% FPL</b>  | <i>An ABD 80% FPL recipient's financial eligibility requirements are in section M1460.225 below.</i> |
| 5. <b>MN Groups</b>    | Medically needy (MN) groups are listed in section M1460.230 below.                                   |
| 6. <b>MI Groups</b>    | MI groups are listed in section M1460.240 below.   |

## M1460.201 SSI RECIPIENTS

### A. Introduction

An SSI recipient in a nursing facility, or who receives Medicaid CBC waiver services, must meet the Medicaid nonfinancial, asset transfer and resource eligibility requirements to be eligible for Medicaid payment of LTC services. The SSI recipient's resource eligibility must be determined if he owns a real property resource; the receipt of SSI meets the Medicaid income eligibility requirements. The covered group eligibility requirements for SSI recipients are in section M0320.201.

- |                        |  |
|------------------------|--|
| 1. <b>Medicaid CBC</b> | An SSI recipient who receives Medicaid CBC waiver services in his community residence usually continues to receive SSI with no change. If a recipient moves to another person's home to receive Medicaid CBC, his SSI payment may be affected. When a Medicaid SSI recipient begins receiving Medicaid CBC waiver services, asset transfer and resource eligibility must be evaluated. As long as the individual receives SSI, he is categorically needy if he meets the Medicaid nonfinancial and resource eligibility rules. |
| 2. <b>Facility</b>     | SSI recipients in nursing facilities are subject to the reduced SSI benefit rate of \$30 for their personal needs. If they have other countable income that exceeds \$30, their SSI will be canceled. SSI recipients may continue to receive their regular monthly SSI benefit for 3 months if they are considered temporarily institutionalized. Individuals who receive SSI after admission to a facility are categorically needy if they meet the Medicaid nonfinancial and resource eligibility rules.                     |

### B. Policy

- |                          |   |
|--------------------------|---|
| 1. <b>Nonfinancial</b>   | Evaluate the non-financial Medicaid eligibility rules in section M1410.020. An SSI recipient meets an ABD covered group.  |
| 2. <b>Asset Transfer</b> | Determine if the recipient meets the asset transfer policy in subchapter M1450.   |
| 3. <b>Resources</b>      | <p><b>a. Determine Countable Resources</b></p> <p>Determine if the SSI recipient has the following real property resource(s):</p> <ol style="list-style-type: none"> <li>1) equity in non-exempt property contiguous to his home which exceeds \$5,000 and none of the real property exclusions in sections M1130.100, M1130.140, S1130.150, or M1130.160 apply to the property;</li> </ol> |

**Yes:** eligible as CN; STOP. Go to section M1460.660 for enrollment and subchapter M1470 for patient pay. (Remember to review asset transfer to evaluate whether Medicaid payment may be made for LTC services).

**No:** Go to B below.

**B. Covered Group**

Is person already enrolled in Medicaid in a covered group eligible for LTC services?

**Yes:** Go to E "Resources" below.

**No:** Is person F&C?

**Yes:** Determine if he meets F&C MI group first (section M1460.240) go to D "Income" below.

**No:** Go to C below.

**C. Is person ABD?**

**Yes:** Go to D "Income" below.

**No:** Is person in Hospice?

**Yes:** Determine as Hospice; see section M0320.205.

**No:** ineligible for Medicaid, does not meet a covered group; STOP. Go to section M1460.660 for notice procedures.

**D. Income (See M1460.600)**

**1. Person is F&C MI**

Determine countable income *using* chapter M07.

Compare income to appropriate F&C MI income limit.

Is income within F&C MI limit?

**Yes:** eligible as F&C MI, STOP. Go to section M1460.660 for enrollment and subchapter M1470 for patient pay.

**No:** not eligible as F&C MI, go to item 2 below.

**2. Person Is Not F&C MI**

Is person ABD?

**Yes:** Determine if gross income is less than or equal to *the 300% SSI income limit using chapter S08 and section M1460.600 below* to determine *gross* income.

Is *gross* income less than or equal to *300% SSI income limit*?

**Yes:** Go to section E "Resources" below.

**No:** Go to *section M1460.410 "Steps for Determining MN Eligibility" below*.

**No:** Does person meet the F&C 300% SSI or Hospice covered group?

**Yes:** Go to item 3 “Determine 300% SSI income” *below*.

**No:** Go to section M1460.410 “Steps for Determining MN Eligibility.”

**3. Determine if Gross Income is Less Than or Equal to 300% SSI**

Determine if gross monthly income is less than or equal to the 300% SSI income limit using chapter S08 and section M1460.600 below for **ABD and F&C** individuals.

*Is gross income less than or equal to 300% SSI income limit?*

**Yes:** go to section E “Resources” *below*.

**No:** go to section M1460.410 “Steps for Determining MN Eligibility” *below*.

**E. Resources (See M1460.500)**

**1. Determine CN/CNNMP Resources**

**a. ABD groups**

*1) Unmarried Individual or Married Individual with no Community Spouse*

- a) *300% SSI group:* Determine ABD countable resources *using* chapter S11.

Compare to ABD CN/CNNMP resource limit = \$2,000 for 1 person. *If the individual is not eligible due to excess resources, evaluate eligibility in the ABD 80% FPL covered group. See item b) below.*

- b) *ABD 80% FPL group:* Using chapter S08 and M1460.600, determine if countable income is within the ABD 80% FPL income limit contained in M0810.002.A.5. *If countable income is less than or equal to 80% FPL, determine countable resources using chapter S11 and Appendix 2 to chapter S11. NOTE: the 6-month home exclusion does not apply to this covered group.*

Compare to ABD CN/CNNMP resource limit = \$2,000 for 1 person.

*2) Married Individual with Community Spouse*

Determine ABD countable resources *using* chapter S11 and subchapter M1480.

Compare to ABD CN/CNNMP resource limit = \$2000 for 1 person

**b. F&C groups**

*1) Unmarried Individual or Married Individual with no Community Spouse*

- Determine F&C CN/CNNMP countable resources *using* chapter M06 for the unmarried institutionalized individual.
- Compare to F&C CN/CNNMP resource limit = \$1,000.

Each month must be evaluated separately. These patients will always be enrolled after the month being evaluated has passed. Use eligibility Type 4 to enroll.

**5. Spenddown--  
CBC Patients**

**Do not project CBC waiver services costs.** Eligibility is evaluated on a monthly basis. Determine spenddown eligibility AFTER the month has passed, by deducting old bills and carry-over expenses first, then (on a daily basis) chronologically deducting the daily CBC cost at the **private** daily rate and other medical expenses **as they are incurred**. If the spenddown balance is met on a date within the month, the patient is eligible effective the first day of the month in which the spenddown was met. Eligibility ends the last day of the month.

Each month must be evaluated separately. These patients will always be enrolled after the month being evaluated has passed. Use eligibility Type 4 to enroll.

## M1460.500 RESOURCE DETERMINATION

### A. Introduction

The following sections describe the resource eligibility rules that are applicable to individuals in long-term care.

### B. Resource Limits

**1. ABD Groups**

*ALL* aged, blind and disabled (ABD) covered groups = \$2,000 per individual.

**2. F&C Groups**

*F&C 300% SSI and Hospice groups* = \$1,000, regardless of the number of individuals in the assistance unit.

MN groups = \$2,000 for an individual. \$3,000 for 2 persons (pregnant woman with 1 unborn child; add \$100 for each additional unborn child).

*There are no resource requirements for any other F&C covered group.*

### C. Budget Period

The budget period for determining long-term care resource eligibility is always one month.

## M1460.510 DETERMINING COUNTABLE RESOURCES

### A. Married Individual

**1. With A  
Community  
Spouse**

See **subchapter M1480** for the rules to determine the **institutionalized individual's resource eligibility** when he is married and his spouse is a community spouse (the spouse is not in a medical institution or nursing facility).

## a. Community Spouse Not Receiving Medicaid CBC Waiver Services

When both husband and wife have applied for Medicaid and one is institutionalized, and the community spouse does NOT receive Medicaid CBC waiver services, the community spouse's eligibility is processed as a noninstitutionalized individual.

NOTE: Follow resource determination rules found in chapter S11 for ABD covered groups, and in chapter M06 for F&C covered groups. The community spouse's resource eligibility is determined as a couple in the month the other spouse becomes institutionalized, and as an unmarried individual for the following months.

## b. Community Spouse Receives Medicaid CBC Waiver Services

When both husband and wife have applied for Medicaid and one is institutionalized in a medical facility, and the community spouse receives Medicaid CBC waiver services, the community spouse's eligibility is processed as a married institutionalized Medicaid CBC recipient in the initial month of Medicaid CBC and afterwards, using the policy and procedures in subchapter M1480.

## 2. Both Spouses In A Medical Facility (No Community Spouse)

When the institutionalized individual's spouse is NOT a community spouse (the spouse is in a medical institution or nursing facility), the policy and procedures in subchapter M1460 that apply to an **unmarried individual** apply to the institutionalized individual effective the month of institutionalization and apply to the individual's spouse if the spouse also applies for Medicaid. Do not use subchapter M1480 because the individual is not an "institutionalized spouse" as defined in M1480.

When both husband and wife are institutionalized in a facility, the policy and procedures in subchapter M1460 that apply to **unmarried** individuals apply to each spouse in the initial month of institutionalization and afterwards.

## 3. Both Spouses Receive Medicaid CBC

When both spouses have applied for Medicaid and both receive Medicaid CBC waiver services, each spouse must be evaluated using policy and procedures in subchapter M1480.

## B. Unmarried Individual

## 1. ABD Covered Groups

An institutionalized individual is an assistance unit of 1 person, considered living separately from his family. No resources are deemed available from the individual's spouse. To determine the ABD resource eligibility of an unmarried individual, or married individual with no community spouse, use the ABD Resource policy and procedures found in chapter S11 and in section M1460.500.

*For the ABD 80% FPL covered group, use the ABD resource policy and procedures in chapter S11 and Appendix 2 to chapter S11.*

The maximum allowable resource limit for an ABD individual is \$2,000.

NOTE: If the individual's adult child or parent is under age 65 and the adult child's or parent's disability has not been established by Medicaid, *Civil Service*, or by Social Security through receipt of SSA or SSI disability, disability can be established by submitting a medical history and disability report to *Disability Determination Services (DDS)*. See section M0310.112 for DDS information.

**3. ABD Groups--  
Home  
Exclusion Does  
Not Apply To  
Contiguous  
Property**

For unmarried individuals and married individuals with no community spouses, the home exclusion for ABD covered groups applies to the home (dwelling) and the plot of land on which the home is located, and to the property contiguous to the home that comes under the home exclusion by using one of the two different calculations in section M1130.100. The home exclusion DOES NOT apply to the property contiguous to the home that does **not** come under the home definition in section M1130.100 A.2.

If the ABD individual owns property contiguous to his home, the value of the non-home contiguous property is a countable resource, regardless of whether the home is occupied by a dependent relative, unless the contiguous property can be excluded for another reason listed in subchapter S1130.

**D. 6-Months Home  
Exclusion**

The home is excluded as a primary residence during temporary absences for visits or to obtain medical treatment. The former home property is excluded as a resource for 6 months, beginning with the month **following** the month institutionalization begins.

**1. ABD Groups--  
Exclusion Does  
Not Apply To  
Contiguous  
Property**

The 6-month home exclusion for ABD covered groups applies to the home (dwelling) and the plot of land on which the home is located, and to the property contiguous to the home that comes under the home exclusion by using one of the two different calculations in section M1130.100. The 6-month home exclusion DOES NOT apply to the property contiguous to the home that does **not** come under the home definition in section M1130.100 A.2.

Therefore, if the ABD individual owns property contiguous to his home, the value of the non-home contiguous property is a countable resource, regardless of the individual's temporary absence, unless the contiguous property can be excluded for another reason in subchapter S1130.

**2. Facility  
Admission**

The former home property is excluded for 6 full months beginning with the month **following** the month of institutionalization in a medical facility. The property is no longer "home property" after 6 months of absence due to institutionalization. An individual who has been receiving Medicaid CBC waiver services in his own home and who then enters a nursing facility receives the six months former home exclusion starting with the month following the month of admission to the facility.

Individuals re-admitted to a medical facility 30 days or more after discharge will have the six-months former home exclusion start over again.

**EXAMPLE #1:** Mr. G is an unmarried aged individual who has been receiving Medicaid CBC waiver services in his home since February 2, 1997. He was admitted to a nursing facility on June 20, 1998. He owns his home, which has no contiguous property. His former home property is excluded for 6 months after admission, beginning July 1, 1998 and ending December 31, 1998

**3. Medicaid CBC Waiver Services Admission**

A Medicaid CBC waiver services recipient who is living away from the home established as his primary place of residence, in order to receive medical care, is entitled to the six months' home exclusion. The six months will start with the month **following** the month in which he left his home.

An individual who is discharged from a nursing facility to go home and receive Medicaid CBC waiver services is considered as living on the home property. The home property, as defined by the appropriate manual section, is excluded while the individual lives there.

**EXAMPLE #2:** Mr. B is an unmarried aged individual living in his home. He was admitted to Medicaid CBC waiver services on January 20, 1999, the day he moved into his daughter's home. He owns his home, which has no contiguous property. His former home property is excluded for 6 months after the month in which he moved to his daughter's home. The 6-months exclusion begins February 1, 1999 and ends July 31, 1999.

**E. After Six Months**

At the end of six months of continuous absence due to institutionalization, the former home property must be counted as an available resource if owned by the recipient, unless it can be excluded for another reason.

**1. Exclude Indefinitely**

The former home property (residence) can be excluded indefinitely when one of the conditions in section M1460.530 C. above is met.

**2. Exclude Under Resource Rules**

If the former residence is not excluded because it is not occupied by an individual who meets the requirements in section M1460.530 C. above, determine if it can be excluded under the resource rules applicable to the individual's covered group.

**a. ABD Covered Groups**

- 1) Reasonable but Unsuccessful Efforts to Sell (section M1130.140).
- 2) Indians' Interest in Trust or Restricted Lands (section S1130.150).
- 3) Other Real Property (section M1130.160).
- 4) Property Essential to Self-support (sections S1130.500 through S1130.510).



**b. F&C Covered Groups**

- 1) Excluded Resources (section M0630.100).
- 2) Reasonable Effort To Sell (CN, CNNMP) (section M0630.105).
- 3) Reasonable Effort To Sell For the Medically Needy (section M0630.110).

**F. Home No Longer Excluded**

If the individual's home property is no longer excluded and the individual has excess resources, cancel Medicaid because of excess resources when the individual does not have Medicare Part A. If the individual has Medicare Part A, evaluate the individual's eligibility as ABD MI, which has more liberal resource requirements and limits.

**1. Individual Has Medicare Part A**

When the individual has Medicare Part A:

- a. compare income with the ABD MI limits; if the income is below one of the ABD MI income limits, then
- b. evaluate the resources using ABD MI policy as found in Chapter S11, Appendix 2.
- c. If eligible as ABD MI only, Medicaid will not pay for nursing facility or CBC waiver services costs. Do the following:
  - prepare and send an Advance Notice of Proposed Action to the recipient;
  - cancel the recipient's coverage in the MMIS, then reinstate the recipient to ABD MI limited coverage;
  - send a DMAS-122 to the provider, stating that the recipient is no longer eligible for full Medicaid coverage because of excess resources, but is eligible for limited ABD MI coverage; beginning (specify the date following the cancel date of the recipient's full coverage), Medicaid will not pay for the individual's care. Do not include any patient pay information on this DMAS-122.
- d. If NOT eligible as ABD MI because of resources and/or income, cancel the recipient's Medicaid. Do the following:
  - prepare and send an "Advance Notice of Proposed Action" to the recipient;
  - cancel the recipient's Medicaid coverage in the MMIS because of excess resources or income;

- send a DMAS-122 to the provider, stating that the recipient's Medicaid will be canceled because of excess resources (and/or income) and the effective date of cancellation. Do not include any patient pay information on this DMAS-122

**2. Individual Does Not Have Medicare Part A**

When the individual DOES NOT have Medicare Part A:

- cancel the recipient's Medicaid coverage in the MMIS because of excess resources;
- prepare and send an Advance Notice of Proposed Action to the recipient;
- send a DMAS-122 to the provider, stating that the recipient's Medicaid will be canceled because of excess resources, and the effective date of cancellation. Do not include any patient pay information on this DMAS-122.

## M1460.540 SUSPENSION PROCEDURES

**A. Policy**

This section applies ONLY to Medicaid recipients:

- who are enrolled in ongoing Medicaid coverage and
- whose patient pay exceeds the Medicaid rate.

**B. Procedures**

If a Medicaid recipient's patient pay exceeds the Medicaid rate and his resources go over the Medicaid resource limit, take the following actions:

**1. For Recipients Who Have Medicare Part A**

**a. Resources Less Than or Equal to ABD MI Resource Limit**

If the recipient's resources are less than or equal to the higher ABD MI resource limit, **determine** if the recipient's income is less than or equal to the QMB, SLMB, or QI income limit.

- When the recipient's income is less than or equal to the QMB, SLMB, or QI income limit:
  - prepare and send an advance notice to reduce the recipient's Medicaid coverage from full benefits to limited benefits (specify the appropriate QMB, SLMB, or QI coverage). Write a note on the notice telling the recipient that:
    - the limited (QMB, SLMB, or QI) benefits will NOT pay for long-term care services, and
    - if he verifies that his resources are less than or equal to the \$2,000 resource limit, he should request reinstatement of full Medicaid benefits.

- b) **cancel** the recipient's full coverage line in the MMIS effective the last day of the month in which the 10-day advance notice period expires, using cancel reason "07". Reinstatement the recipient's coverage with the begin date as the first day of the month following the cancellation effective date, using the appropriate QMB, SLMB or QI PD.
- 2) When the recipient's income exceeds the QMB, SLMB and QI income limits, follow the procedures in 2 below (the procedures for recipients who do not have Medicare Part A).

#### **b. Resources Exceed ABD MI Resource Limit**

If resources are greater than the ABD MI resource limit, follow the procedures in item 2 below (the procedures for recipients who do not have Medicare Part A).

### **2. For Recipients Who Do NOT Have Medicare Part A**

#### **a. Prepare and Send Advance Notice**

Prepare and send an advance notice to cancel the recipient's Medicaid eligibility. Specify the effective date, which is the last day of the month in which the 10-day advance notice period expires. Write a note on the notice telling the recipient that if he verifies that his resources are less than or equal to the \$2,000 resource limit before the specified date (specify the date which is 3 months from the cancel effective date), he should request reinstatement of Medicaid eligibility.

#### **b. Cancel Medicaid Eligibility**

Cancel the recipient's eligibility in the MMIS effective the last day of the month in which the 10-day advance notice period expires.

#### **c. Suspend Case Administratively**

Suspend the case administratively for a maximum of 3 months; do not close the case statistically. The suspension effective date is the effective date of the Medicaid cancellation in the MMIS. While suspended, the case remains open for a maximum of 3 months.

If, by the end of 3 months from the suspension effective date, the individual provides verification that his resources have been reduced to or below the resource limit, document the reduction in resources in the individual's case record. Reinstatement his Medicaid eligibility in the MMIS effective the first day of the month in which his resources are less than or equal to the resource limit.

If the individual does NOT provide verification within 3 months of the suspension effective date that his resources have been reduced to or below the resource limit, close the case administratively and statistically. Do not take any action on his enrollment in the MMIS, because his eligibility has already been canceled. The individual will have to file a new Medicaid application.

**M1460.600 INCOME DETERMINATION**

- A. Introduction** This section provides the income requirements specific to determinations of eligibility for Medicaid participation in payment of long-term care services.
- B. F&C Medically Indigent** If an institutionalized individual meets an F&C Medically Indigent covered group, determine if his income is within the appropriate F&C Medically Indigent income limit. The institutionalized individual is an assistance unit of one person; no income is deemed from responsible relatives. Use the policy and procedures in chapter M07 to determine countable income.
- C. 300% SSI Income Limit Group** For purposes of this section, we refer to the ABD covered group and the F&C covered group of “individuals in medical facilities who have income less than or equal to 300% of the SSI individual payment limit” and “individuals receiving Medicaid waiver services who have income less than or equal to 300% of the SSI individual payment limit” as one covered group. We refer to this one group as “institutionalized individuals who have income within 300% of SSI” or the “300% SSI group.”
- 1. Assistance Unit** The institutionalized individual is an assistance unit of one person; no income is deemed from responsible relatives.
- 2. Income Limit** The income limit for ABD and F&C individuals in the 300% SSI group is 300% of the SSI individual payment limit (see M0810.002 A. 3.).
- 3. Countable Income** **Income sources listed in section M1460.610 are NOT considered income.**  
**Income sources listed in section M1460.611 ARE counted as income.**  
  
All other income is counted. The individual’s gross income is counted; no exclusions are deducted.  
  
To determine an income type or source and to determine how to count the income, use the policy and procedures in chapter S08 for all individuals (both ABD and F&C) in this covered group.  
  
Income is projected for the month for which eligibility for LTC is being determined. This calculation is based upon the income received in the past month unless there is documentation that a change has occurred or can reasonably be expected to occur which will change the amount expected to be received.
- D. ABD 80% FPL Group** If an individual is aged, blind or disabled, determine if his income is less than or equal to 80% of the FPL. See M0810.002.A.5 for the ABD 80% FPL income limits. Use the policy in chapter S08 to determine countable income.
- E. MN Income - All MN Covered Groups** The medically needy (MN) individual income limits are listed in Appendix 5 to subchapter M0710 and in section M0810.002.A.4.

- |                                     |  |
|-------------------------------------|--|
| <b>6. Domestic Travel Tickets</b>   | Gifts of domestic travel tickets [1612(b)(15)].  |
| <b>7. Victim's Compensation</b>     | Victim's compensation provided by a state.   |
| <b>8. Tech-related Assistance</b>   | Tech-Related Assistance for Individuals with Disabilities [ref. P.L. 100-407].   |
| <b>9. \$20 General Exclusion</b>    | <p>\$20 a month general income exclusion for the unit.</p> <p><b>EXCEPTION:</b> Certain veterans (VA) benefits are not subject to the \$20 income exclusion. Refer to subchapter S0830 for complete explanation of which VA payments are entitled to the \$20 general exclusion.</p>   |
| <b>10. PASS Income</b>              | Any unearned income used to fulfill an SSI approved plan to achieve self-support (PASS). See item 12 below for earned income used to fulfill a PASS [1612(b) (4)(A) & (B)].  |
| <b>11. Earned Income Exclusions</b> | <p>The following earned income exclusions are not deducted for the 300% SSI group:</p> <ul style="list-style-type: none"> <li>a. Up to \$1,370 per month, but not more than \$5,520 in a calendar year, of the earned income of a blind or disabled student child [1612(b) (1)].</li> <li>b. Any portion of the \$20 monthly general income exclusion which has not been excluded from unearned income in that same month [1612(b) (2)(A)].</li> <li>c. \$65 of earned income in a month [1612(b) (4)(C)].</li> <li>d. IRWE - earned income of disabled individuals used to pay impairment-related work expenses [1612(b) (4)(B)].</li> <li>e. One-half of remaining earned income in a month [1612(b) (4)(C)].</li> <li>f. BWE - Earned income of blind individuals used to meet work expenses [1612(b) (4)(A)].</li> <li>g. Earned income used to fulfill an SSI approved plan to achieve self-support (PASS) [1612(b) (4)(A) &amp; (B)].</li> </ul> |
| <b>12. Child Support</b>            | Child support payments received from an absent parent for a blind or Disabled child [1612(b) (9)].   |

**13. Native  
American  
Funds**

The following Native American funds (only exclude for ABD MN groups):

- a. Puyallup Tribe [ref. P.L. 101-41]
- b. White Earth Reservational Land Settlement [ref. P.L. 99-264]
- c. Chippewas of Mississippi [ref. P.L. 99-377]
- d. Saginaw Chippewas of Michigan [ref. P.L. 99-346]
- e. Shoalwater Bay Indian Tribe [ref. P.L. 98-432]
- f. Wyandotte Tribe [ref. P.L. 98-602]
- g. Chippewas of Lake Superior [ref. P.L. 99-146]
- h. Cow Creek Band of Umpqua [ref. P.L. 100-139]
- i. Coushatta Tribe of Louisiana [ref. P.L. 100-411]
- j. Wisconsin Band of Potawatomi [ref. P.L. 100-581]
- k. Seminole Indians [ref. P.L. 101-277]
- l. receipts from land distributed to:
  - Pueblo of Santa Ana [ref. P.L. 95-498]
  - Pueblo of Zia [ref. P.L. 95-499].

**14. State/Local  
Relocation**

State or local relocation assistance [1612(b) (18)].

**15. USC Title 37  
Section 310**

Special pay received pursuant to section 310 of title 37, United States Code [1612(b)(20)].

NOTE: For additional F&C medically needy (MN) income exclusions, go to Chapter M07. For additional ABD medically needy (MN) income exclusions, go to Chapter S08.

**M1460.620 RESERVED****M1460.640 INCOME DETERMINATION PROCESS FOR STAYS LESS  
THAN 30 DAYS****A. Policy - Individual  
in An Institution  
for Less Than 30  
Days**

This subsection is applicable ONLY if it is known that the time spent in the institution has been, or will be, less than 30 days. If the individual is institutionalized for less than 30 days, Medicaid eligibility is determined as a non-institutionalized individual because the definition of “institutionalization” is not met. If there is no break between a hospital stay and admission to a nursing facility or Medicaid CBC waiver services, the hospital days count toward the 30 days in the “institutionalization” definition.

**B. Recipient**

If a Medicaid recipient is admitted to a medical institution for less than 30 days, go to subchapter M1470 for patient pay policy and procedures.

**C. Applicant**

If the individual is NOT a Medicaid recipient and applies for Medicaid determine the individual’s income eligibility as a non-institutionalized individual. Go to Chapter M07 for F&C or S08 for ABD to determine the individual’s income eligibility.

# TABLE OF CONTENTS

## M14 LONG-TERM CARE

### M1480 MARRIED INSTITUTIONALIZED INDIVIDUALS' ELIGIBILITY & PATIENT PAY

Section Page

#### GENERAL

General.....	M1480.000 .....	1
Definitions.....	M1480.010 .....	2
Inability to Complete the Resource Assessment- Undue Hardship .....	M1480.020 .....	7

#### RESOURCES

Resource Assessment Rules.....	M1480.200 .....	8a
Resource Assessment Without Medicaid		
Application.....	M1480.210 .....	9
Resource Assessment With Medicaid Application.....	M1480.220 .....	13
Resource Eligibility of Institutionalized Spouse.....	M1480.230 .....	17
Spousal Resource Standards.....	M1480.231 .....	18
Initial Eligibility Determination Period .....	M1480.232 .....	18
Initial Eligibility - Retroactive Months .....	M1480.233 .....	25
Community Spouse Resource Allowance (CSRA).....	M1480.240 .....	29
CSRA Calculation Procedures.....	M1480.241 .....	30
Protected Period of Eligibility .....	M1480.242 .....	34
When Resources Exceed The Resource Limit.....	M1480.250 .....	43
Re-application After Eligibility Canceled.....	M1480.255 .....	44
Suspension Procedures .....	M1480.260 .....	45

#### INCOME

Income Eligibility of Institutionalized Spouse.....	M1480.300 .....	47
300% SSI and ABD 80% FPL Income Eligibility		
Determination.....	M1480.310 .....	49
Retroactive MN Income Determination.....	M1480.320 .....	51
Medically Needy Income & Spenddown .....	M1480.330 .....	52
Facility Patients With Spenddown Liability Greater Than Medicaid Rate & All MN CBC Patients .....	M1480.340 .....	56
Not Previously On Spenddown .....	M1480.341 .....	57
Previously On Spenddown .....	M1480.342 .....	60
Spenddown Entitlement .....	M1480.350 .....	65

Patient Pay .....	M1480.400 .....	66
Maintenance Standards & Allowances .....	M1480.410 .....	66
Patient Pay for ABD 80% FPL and 300% SSI		
Institutionalized Spouse .....	M1480.420 .....	66
ABD 80% FPL and 300% SSI Patient Pay		
Calculation .....	M1480.430 .....	67
Medically Needy Patient Pay .....	M1480.440 .....	78
Facility Patient Pay--Spenddown Liability Less		
Than or Equal To Medicaid Rate .....	M1480.450 .....	79
Facility Patient Pay--Spenddown Liability		
Greater Than Medicaid Rate .....	M1480.460 .....	83
CBC--MN Institutionalized Spouse Patient Pay .....	M1480.470 .....	87

## NOTICES & APPEALS

Notices & Appeals .....	M1480.500 .....	92
Notification .....	M1480.510 .....	92
Appeals .....	M1480.520 .....	95

## APPENDIX

Medicaid Resource Assessment Request .....	Appendix 1 .....	1
Medicaid Resource Assessment .....	Appendix 2 .....	1
Notice of Medicaid Resource Assessment .....	Appendix 3 .....	1
Institutionalized Spouse Resource Eligibility Worksheet .....	Appendix 4 .....	1
Intent to Transfer Assets to Community Spouse .....	Appendix 5 .....	1
<i>Separated Spouse Expected Contribution Scale -</i>		
<i>Institutionalized Recipients .....</i>	<i>Appendix 6 .....</i>	<i>1</i>



institutionalization) were \$131,000. The spousal share is ½ of \$131,000, or \$65,500.

On the Medicaid Resource Assessment form, the worker lists the couple's resources as of December 1, 1995 as follows:

<u>Resource</u>	<u>Owner</u>	<u>Countable</u>	<u>Countable Value</u>
Home	Mr & Mrs	No	0
Savings	Mr & Mrs	Yes	\$100,000
CD	Mr	Yes	\$ 31,000

\$131,000 Total Value of Couple's Countable Resources

\$ 65,500 Spousal Share

In the eligibility evaluation, the worker uses the spousal share amount (\$65,500) as one factor to determine the spousal protected resource amount (PRA) that is subtracted from the couple's current resources to determine the institutionalized spouse's resource eligibility.

#### **F. Notice Requirements**

Do not send the Notice of Medicaid Resource Assessment when a resource assessment is completed as a part of a Medicaid application.

Include a copy of the Medicaid Resource Assessment form with the Notice of Action on Medicaid that is sent when the eligibility determination is completed.

## **M1480.230 RESOURCE ELIGIBILITY OF INSTITUTIONALIZED SPOUSE**

### **A. Introduction**

This section contains the resource rules that apply to the institutionalized spouse's eligibility.

If the community spouse applies for Medicaid, do not use the rules in this subchapter to determine the community spouse's eligibility. Use the financial eligibility rules for a non institutionalized person in the community spouse's covered group.

### **B. Policy**

An institutionalized spouse meets the resource eligibility requirements for Medicaid if the difference between the couple's total countable resources at the time of application and the spousal protected resource amount (PRA) is equal to or less than \$2,000.

In initial eligibility determinations for the institutionalized spouse, the spousal share of resources owned by the couple **at the first moment of the first day of the first month of the first continuous period of institutionalization** that began on or after September 30, 1989, remains a constant factor in determining the spousal PRA.

Once an institutionalized spouse has established Medicaid eligibility as an institutionalized spouse, count only the institutionalized spouse's resources when determining the institutionalized spouse's Medicaid eligibility. Do not count or deem the community spouse's resources available to the institutionalized spouse.

**C. "Institutionalized Spouse Resource Eligibility Worksheet"**

Use the "Institutionalized Spouse Resource Eligibility Worksheet" to determine the institutionalized spouse's resource eligibility. The worksheet is in Appendix 4 to this subchapter.

## **M1480.231 SPOUSAL RESOURCE STANDARDS**

**A. Introduction**

This section provides the amounts and the effective dates of the standards used to determine an institutionalized spouse's initial and ongoing resource eligibility. Use the standard in effect on the date of the institutionalized spouse's Medicaid application. Definitions of the terms are found in section M1480.010.

**B. Spousal Resource Standard**

*\$18,552      1-1-04*

*\$18,132      1-1-03*

**C. Maximum Spousal Resource Standard**

*\$92,760      1-1-04*

*\$90,660      1-1-03*

## **M1480.232 INITIAL ELIGIBILITY DETERMINATION PERIOD**

**A. Policy**

An institutionalized spouse meets the resource eligibility requirements for Medicaid in the application month if the difference between the couple's total countable resources **at the time of application** and the spousal protected resource amount (PRA) is equal to or less than \$2,000.

**1. First Application**

Use the procedures in item B below for the initial resource eligibility determination for an institutionalized spouse's first application for Medicaid in a continuous period of institutionalization that began on or after 9-30-89.

**2. Subsequent Applications**

**a. Medicaid Eligibility For LTC Services Achieved Previously**

If an individual achieved Medicaid eligibility as an institutionalized spouse during a period of institutionalization that began on/after 9-30-89, regardless of whether the period of institutionalization is the same continuous period covered by the previous application(s), **do not consider the couple's resources. Use only the institutionalized spouse's resources.** Use the policy and procedures in section M1480.255 to determine the institutionalized individual's financial eligibility.

**M1480.250 WHEN RESOURCES EXCEED THE RESOURCE LIMIT****A. Introduction**

When the institutionalized spouse is not eligible because of excess resources, the institutionalized spouse is not eligible for any Medicaid coverage if he does not have Medicare Part A. Deny the application because of excess resources.

If he has Medicare Part A, the institutionalized spouse may be eligible for limited coverage QMB, SLMB or QI Medicaid (which will not cover the cost of the LTC services) because the resource requirements and limits are different.

**B. Individual Has Medicare Part A**

If the institutionalized spouse has Medicare Part A, evaluate eligibility for QMB, SLMB or QI using the same resource calculation but comparing the institutionalized spouse's countable resources to the higher QMB/SLMB/QI resource limit. The institutionalized spouse cannot be eligible for QDWI Medicaid because the resource requirements and resource limits are the same as MN; the institutionalized spouse has excess resources for QDWI Medicaid. [Section 1924(a)(1)].

If the countable resources are within the QMB/SLMB/QI limit for one person, the institutionalized spouse is resource-eligible for QMB, SLMB or QI. Determine countable income.

**1. QMB Eligible**

If countable income is within the QMB limit, the institutionalized spouse is eligible for limited QMB Medicaid. However, the only LTC service that Medicaid will cover for a QMB is the Medicare coinsurance for skilled nursing facility (SNF) care when the SNF care is covered by Medicare.

**2. SLMB or QI Eligible**

If income exceeds the QMB limit but is within the SLMB or QI limit, the institutionalized spouse is eligible for limited SLMB or QI Medicaid. Medicaid will not cover any of the cost of any LTC services for an SLMB *or* QI recipient. Medicaid will only pay the recipient's Medicare Part B premium for an SLMB or QI.

**3. Notice**

In the Notice of Action on Medicaid, notify the individual, the community spouse and the authorized representative (if any) of:

- the denial of Medicaid eligibility for LTC services' payment because of resources over the \$2,000 Medicaid resource limit;
- when **QMB eligible**, approval of limited QMB Medicaid coverage which will only pay: Medicare premiums, Medicare deductibles and Medicare coinsurance; or

- when **SLMB or QI eligible**, approval of limited Medicaid coverage which will only pay (all or part of) the Medicare Part B premium; Medicaid will **not** pay for any medical services.

**C. Individual Does Not Have Medicare Part A**

If the institutionalized spouse does not have Medicare Part A, deny the Medicaid application because of excess resources.

In the Notice of Action on Medicaid, notify the individual, the community spouse and the authorized representative (if any) of the denial of Medicaid eligibility because of resources over the \$2,000 Medicaid resource limit.

**D. Resources Reduced**

An institutionalized spouse **cannot** establish resource eligibility by reducing resources within the month. The institutionalized spouse may become eligible for Medicaid payment of LTC services when the institutionalized spouse's resources are equal to or below the \$2,000 CNNMP/MN resource limit as of the first moment of the first day of a calendar month.

**M1480.255 RE-APPLICATION AFTER ELIGIBILITY CANCELED**

**A. Policy**

When an individual established Medicaid eligibility as an institutionalized spouse during a period of institutionalization that began on/after 9-30-89, then had Medicaid coverage canceled and then reapplies for Medicaid, do not consider the couple's resources. **Use only the institutionalized spouse's resources.**

For the application's retroactive month(s), determine resources using only the institutionalized spouse's resources in each retroactive month. If the institutionalized spouse's countable resources exceed the Medicaid resource limit in a retroactive month, the institutionalized spouse is NOT eligible for that month.

**B. Example--Re-application After Initial Eligibility Established, Then Canceled**

**EXAMPLE #14:** Mr B's first continuous period of institutionalization began on 9-20-92. His current continuous period of institutionalization began on 11-12-96. He first applied for Medicaid on February 20, 1998. Mrs. B is his community spouse. All but \$500 of the couple's resources are in Mrs. B's name.

- Step 1:** The couple's total resources as of September 1, 1992 were \$100,000.
- Step 2:**  $\$100,000 \div 2 = \$50,000$ . The spousal share is \$50,000.
- Step 3:** The couple's total resources as of February 1998 (the application month) are \$51,000.
- Step 4:** The PRA is determined:
- \$50,000(the spousal share, which is less than the \$80,760 maximum spousal resource standard at application);
  - \$16,152 (the spousal resource standard at application),
  - \$ 0 (amount designated by DMAS Hearing Officer),
  - \$ 0 (amount transferred pursuant to court support order)

The PRA is \$50,000.

**Step 5:**

\$51,000	couple's resources in application month
<u>- 50,000</u>	PRA
\$ 1,000	countable to Mr. B

**Step 6:** Since \$1,000 is less than the \$2,000 resource limit, Mr. B is resource-eligible for Medicaid in February 1998, the application month. Because \$50,500 of the couple's total resources are in Mrs. B's name, the PRA does not exceed the resources in the community spouse's name and Mrs. B has no CSRA. Mr. B continues eligible in the months following the application month because his resources are less than the \$2,000 limit.

On May 3, 1998, Mr. B begins receiving income which makes his income exceed the income limit. Mr. B's Medicaid coverage is canceled effective May 31, 1998, and he is placed on a spenddown for June 1998. He must reapply for Medicaid if he wants his eligibility determined again.

**Re-application:** Mr. B reapplies for Medicaid on December 6, 1998. He does not request retroactive coverage. He is still in the same period of institutionalization that began 11-12-96. This is NOT an initial eligibility determination because he established Medicaid eligibility as an institutionalized spouse in February 1998. Therefore, only Mr. B's resources are considered when determining his eligibility based on his new Medicaid application. His resources total \$900, so he is resource-eligible.

When the worker asked Mrs. B if she had transferred or given away any money, she reported that she gave some money to their son. The agency determines that the asset transfer does not affect Mr. B's eligibility for Medicaid payment of LTC services because the amount transferred was less than the average cost of nursing facility care at the time of transfer. Mr. B's income exceeds the limit and his application is denied because of excess income. He is placed on a spenddown.

## **M1480.260 SUSPENSION PROCEDURES**

**A. Policy** This section applies ONLY to Medicaid recipients:

- who are enrolled in ongoing Medicaid coverage and
- whose patient pay exceeds the Medicaid rate.

**B. Procedures** If a Medicaid recipient's patient pay exceeds the Medicaid rate and his resources go over the Medicaid resource limit, take the following actions:

- 1. For Recipients Who Have Medicare Part A**
  - a. Resources Less Than or Equal to ABD MI Resource Limit**

If the recipient's resources are less than or equal to the higher ABD MI resource limit, determine if the recipient's income is less than or equal to the

QMB, SLMB or QI income limit (the recipient's resources exceed the QDWI resource limit, which is the same as the Medicaid resource limit).

- 1) When the recipient's income is less than or equal to the QMB, SLMB or QI income limit:
  - a) prepare and send an advance notice to reduce the recipient's Medicaid coverage from full coverage to limited coverage (specify the appropriate QMB, SLMB or QI coverage). Write a note on the notice telling the recipient that:
    - the limited (QMB, SLMB or QI) coverage will NOT pay for long-term care services, and
    - if he verifies that his resources are less than or equal to the \$2,000 resource limit, he should request reinstatement of full Medicaid coverage.
  - b) cancel the recipient's full coverage line in the MMIS effective the last day of the month in which the 10-day advance notice period expires, using cancel reason "07". Reinstatement the recipient's coverage with the begin date as the first day of the month following the cancellation effective date, using a QMB-only PD.
- 2) When the recipient's income exceeds the QMB, SLMB and QI income limits, follow the procedures in *item 2* below (the procedures for recipients who do not have Medicare Part A).

**b. Resources Exceed ABD MI Resource Limit**

If resources are greater than the ABD MI resource limit, follow the procedures in *item 2* below (the procedures for recipients who do not have Medicare Part A).

**2. For Recipients Who Do NOT Have Medicare Part A**

**a. Prepare and Send Advance Notice**

Prepare and send an advance notice to cancel the recipient's Medicaid coverage. Specify the effective date, which is the last day of the month in which the 10-day advance notice period expires. Write a note on the notice telling the recipient that if he verifies that his resources are less than or equal to the \$2,000 resource limit before the specified date (specify the date which is 3 months from the cancel effective date), he should request reinstatement of Medicaid coverage.

The community spouse's income is used only to determine the community spouse monthly income allowance, if any. If the community spouse is not entitled to a monthly income allowance from the institutionalized spouse, the community spouse may have an expected contribution to the institutionalized spouse. See Appendix 6 to this subchapter to determine the community spouse's expected contribution.

**4. Income  
Determination**

For purposes of the income eligibility determination of a married institutionalized spouse, regardless of the individual's covered group, income is determined using the income eligibility instructions in section M1480.310 below and chapter S08.

For individuals who are within a spenddown budget period prior to the month in which they become institutionalized, prorate and shorten the spenddown budget period to include months **prior to admission** to long-term care services. A separate monthly budget period is established for each month of receipt of long-term care services.

**5. Post-eligibility  
Treatment of  
Income**

After an institutionalized spouse is determined eligible for Medicaid, his or her patient pay must be determined. See the married institutionalized individuals' patient pay policy and procedures in section M1480.400 below.

## **M1480.310 300% SSI AND ABD 80% FPL INCOME ELIGIBILITY DETERMINATION**

**A. Introduction**

This section provides those income requirements specific to determinations of eligibility for Medicaid participation in payment of long-term care services.

*For ABD individuals, first determine the individual's eligibility in the 300% SSI covered group. If the individual is ineligible in the 300% SSI covered group due to excess resources, determine the individual's eligibility in the ABD 80% FPL covered group.*

For purposes of this section, we refer to the ABD covered group and the F&C covered group of "individuals in medical facilities who have income less than or equal to 300% of the SSI individual payment limit" and "individuals receiving Medicaid waiver services who have income less than or equal to 300% of the SSI individual payment limit" as one covered group. We refer to this one group as "institutionalized individuals who have income within 300% of SSI" or the "300% SSI group."

**B. 300% SSI Group**

The income limit for ABD and F&C individuals in the 300% SSI group is 300% of the SSI individual payment limit (see M0810.002.A.3).

**1. Gross Income      Income sources listed in section M1460.610 are not considered as income.**

**Income sources listed in section M1460.611 ARE counted as income.**

All other income is counted. The institutionalized spouse's gross income is counted; no exclusions are subtracted.

To determine an income type or source and to determine how to count the income, use the policy and procedures in chapter S08 for all individuals (ABD and F&C) in the 300% SSI group.

Income is projected for the month for which eligibility for LTC is being determined. This calculation is based upon the income received in the past month unless there is documentation that a change has occurred or can reasonably be expected to occur which will change the amount expected to be received.

**2. Income Less Than or Equal to 300% SSI Limit**      If the individual's gross income is less than or equal to the 300% SSI income limit, enroll the individual in the appropriate CNNMP PD and determine patient pay according to the policy and procedures found in section M1480.400.

**a. Individual Has Medicare Part A**

If the individual has Medicare Part A, determine if his income is within the QMB income limit. Calculate the individual's countable income for QMB according to chapter S08, and compare to the QMB limit. If the individual's gross income is less than or equal to the QMB limit, enroll the recipient with the appropriate CNNMP dual-eligible QMB program designation (PD):

- Aged = 22
- Blind = 42
- Disabled = 62

If the income is over the QMB limit, enroll the recipient with the appropriate CNNMP non-QMB PD:

- Aged = 20
- Blind = 40
- Disabled = 60

**b. Individual Does Not Have Medicare Part A**

If the individual does NOT have Medicare Part A, enroll the ABD recipient with the appropriate CNNMP PD:

- Aged = 20
- Blind = 40
- Disabled = 60



Enroll the F&C recipient with the appropriate CNNMP PD:

- Institutionalized child under age 21 = 82
- Institutionalized F&C individual age 21 or older = 60.

**3. Income  
Exceeds 300%  
SSI Limit**

If income exceeds the 300% SSI limit, evaluate the institutionalized spouse as MN. Go to section M1480.330 below.

**C. ABD 80% FPL**

The income limit for the ABD 80% FPL covered group is 80% of the federal poverty level (see M0810.002.A.5). See section M0320.210 for details about this covered group.

The ABD income policy in chapter S08 is used to determine countable income for the ABD 80% FPL covered group. Income is projected for the month for which eligibility for LTC is being determined. This calculation is based upon the income received in the past month unless there is documentation that a change has occurred or can reasonably be expected to occur which will change the amount expected to be received.

If the individual's gross income is less than or equal to the 80% FPL income limit, enroll the individual in the MMIS with the appropriate ABD 80% FPL PD and determine patient pay according to the policy and procedures found in section M1480.400. The ABD 80% FPL PDs are:

- Aged = 29
- Blind = 39
- Disabled = 49

February spenddown eligibility evaluated.

## **M1480.350 SPENDDOWN ENTITLEMENT**

### **A. Entitlement After Spenddown Met**

When an institutionalized spouse meets a spenddown within a month, the begin date of eligibility will be the first day of the month in which the spenddown was met. Eligibility will end on the last day of the month in which the spenddown was met.

### **B. Procedures**

#### **1. Coverage Dates**

Coverage begin date is the first day of the month; the coverage end date is the last day of the month.

#### **2. Program Designation**

##### **a. If the institutionalized spouse does NOT have Medicare Part A:**

- Aged = 18
- Blind = 38
- Disabled = 58
- Child Under 21 in ICF/ICF-MR = 98
- Child Under Age 18 = 88
- Juvenile Justice Child = 85
- Foster Care/Adoption Assistance Child = 86
- Pregnant Woman = 97

##### **b. If the institutionalized spouse has Medicare Part A:**

Compare the individual's monthly MN countable income to the QMB monthly income limit for 1 person (see M0810.002 for the current QMB limit):

1) When income is less than or equal to the QMB limit, enroll using the following PDs:

- Aged = 28
- Blind = 48
- Disabled = 68

2) When income is greater than the QMB limit, enroll using the following PDs:

- Aged = 18
- Blind = 38
- Disabled = 58

#### **3. Patient Pay**

Determine patient pay according to section M1480.400 below.

#### **4. Notices & Re-applications**

The institutionalized spouse on a spenddown must have his eligibility re-evaluated monthly, unless he is in a facility and the spenddown liability is less than or equal to the Medicaid rate. The institutionalized spouse must complete an annual redetermination.

After eligibility is established, the usual reporting and notification processes apply. Send the “Notice of Action on Medicaid” and the “Notice of Obligation for LTC Costs” for the month(s) during which the individual establishes Medicaid eligibility.

## **M1480.400 PATIENT PAY**

- |   |  |
|---|--|
| <b>A. Introduction</b>  | This section contains the policy and procedures for determining an institutionalized spouse’s (as defined in section M1480.010 above) patient pay in all covered groups.       |
| <b>B. Married With Institutionalized Spouse in a Facility</b> | For a married LTC patient with an institutionalized spouse in a facility, NO amount of the patient’s income is deducted for the spouse’s needs in the patient pay calculation. |

## **M1480.410 MAINTENANCE STANDARDS & ALLOWANCES**

- |  |   |                             |         |
|--|---|-----------------------------|---------|
| <b>A. Introduction</b>                                     | This subsection contains the standards and their effective dates that are used to determine the community spouse’s and other family members’ income allowances. The income allowances are deducted from the institutionalized spouse’s gross monthly income when determining the monthly patient pay amount. Definitions of these terms are in section M1480.010 above. |                             |         |
| <b>B. Monthly Maintenance Needs Standard</b>               | \$1,515.00  | 7-1-03                      |         |
|  | \$1,492.50  | 7-1-02                      |         |
| <b>C. Monthly Maintenance Needs Allowance Maximum</b>      | \$2,319   | 1-1-04                      |         |
|  | \$2,266.50  | 1-1-03                      |         |
| <b>D. Excess Shelter Standard</b>                          | \$454.50  | 7-1-03                      |         |
|  | \$447.75  | 7-1-02                      |         |
| <b>E. Utility Standard Deduction (Food Stamps Program)</b> | \$206   | 1 - 3 household members     | 10-1-03 |
|  | \$253   | 4 or more household members | 10-1-03 |
|  | \$194   | 1 - 3 household members     | 10-1-02 |
|  | \$240   | 4 or more household members | 10-1-02 |

## **M1480.420 PATIENT PAY FOR ABD 80% FPL AND 300% SSI INSTITUTIONALIZED SPOUSE**

- |                  |  |
|------------------|--|
| <b>A. Policy</b> | After a 300% SSI or ABD 80% FPL institutionalized spouse has been found eligible for Medicaid, determine his patient pay (post-eligibility treatment of income). |
|------------------|--|

## **TABLE OF CONTENTS**

### **M15 ENTITLEMENT POLICY & PROCEDURES**

#### **M1520.000 MEDICAID ELIGIBILITY REVIEW**

	<b>Section</b>	<b>Page</b>
<b>General Principle .....</b>	<b>M1520.001.....</b>	<b>1</b>
<b>Partial Review .....</b>	<b>M1520.100.....</b>	<b>2</b>
<b>Redetermination Requirements.....</b>	<b>M1520.200.....</b>	<b>3</b>
<b>Medicaid Cancellation or Services Reduction.....</b>	<b>M1520.400.....</b>	<b>9</b>
<b>Notice Requirements.....</b>	<b>M1520.401.....</b>	<b>9</b>
<b>Cancellation Action/Services Reduction .....</b>	<b>M1520.402.....</b>	<b>12</b>
<b>Recipient Requests Cancellation .....</b>	<b>M1520.403.....</b>	<b>12</b>
<b>Extended Medicaid Coverage .....</b>	<b>M1520.500.....</b>	<b>13</b>
<b>Four Month Extension.....</b>	<b>M1520.501.....</b>	<b>13</b>
<b>Twelve Months Extension .....</b>	<b>M1520.502.....</b>	<b>14</b>
<b>Transitional Medicaid .....</b>	<b>M1520.503.....</b>	<b>22</b>
<b>Case Transfers.....</b>	<b>M1520.600.....</b>	<b>22i</b>

#### **APPENDIX**

<b>Notice of Extended Medicaid Coverage.....</b>	<b>Appendix 1 .....</b>	<b>1</b>
--	-------------------------	----------

**M1520.000 MEDICAID ELIGIBILITY REVIEW****M1520.001 GENERAL PRINCIPLE****A. Policy**

A Medicaid recipient's eligibility must be partially reviewed whenever the agency becomes aware of any change in the recipient's circumstances. The agency must determine whether a change affects the recipient's Medicaid eligibility. A review of a specific eligibility requirement or requirements is called a "partial review."

A complete review of all of the recipient's Medicaid eligibility requirements is called a "redetermination." *A redetermination must be completed when any change causes ineligibility in the recipient's covered group.* A recipient's eligibility must be completely redetermined at least once every 12 months.

*When a Medicaid recipient no longer meets the requirements for the covered group under which he is enrolled, the eligibility worker must evaluate the individual's eligibility in all other covered groups prior to canceling his Medicaid coverage.*

**B. Recipient Enters Long-term Care (LTC)**

*When a recipient is admitted to long-term care in a medical facility or is screened and approved for Medicaid waiver services, redetermine the recipient's eligibility as an institutionalized individual using the policy and procedures in chapter M14.*

**C. Procedures For Partial Review and Redeterminations**

The policy and procedures in this subchapter are contained in the following sections:

- the requirements for partial reviews are in section M1520.100;
- the requirements for redeterminations are in section M1520.200;
- *the application redetermination procedures* are in section M1520.300;
- the policy and procedures for canceling a recipient's Medicaid coverage or reducing the recipient's Medicaid services (benefit package) are in section M1520.400;
- the policy and procedures for extended Medicaid coverage are in section M1520.500;
- the policy and procedures for transferring cases within Virginia are in section M1520.600.

**M1520.100 PARTIAL REVIEW****A. Recipient's  
Responsibility**

The recipient has a responsibility to report changes in his circumstances which may affect his eligibility or HIPP premium payments within 10 days from the day the change is known.

**B. Eligibility  
Worker's  
Responsibility**

1. The eligibility worker has a responsibility for keeping a record of any such changes that may be anticipated or scheduled, and for taking appropriate action on those changes. Examples of anticipated changes: receipt of SSA benefits, reevaluation of a parent's temporary disability, the reevaluation date of an individual's disability by *Disability Determination Services (DDS)*, and the expectant child delivery date for a pregnant woman. The worker can use the special review field in the MMIS to set a special review for anticipated change.
2. When changes in a recipient's situation are reported by the recipient or any other source, or when the agency receives information indicating a change in a recipient's circumstances (i.e. SSI purge list, reported transfer of assets), the worker must take action to partially review the recipient's eligibility.
3. A HIPP Application and Medical History Questionnaire must be completed when it is reported that a member of the assistance unit is employed more than 30 hours per week. The eligibility worker must report to the HIPP Unit at DMAS any changes in a recipient's situation that may affect the premium payment.

**C. Time Standard**

Appropriate agency action on a case must be taken within 30 days after receipt by the agency of information indicating that a change in a recipient's circumstances has occurred which affects his eligibility, unless the information is from IEVS or SAVE. If the information is from IEVS or SAVE, action must be taken in 60 days.

**D. Covered Group  
Changes****1. Newborn  
Child**

When a child is born to a Medicaid-eligible woman, the only information needed to enroll the child in Medicaid (child under one covered group) is the child's name and birth date and that the child is living with the mother. This information may be reported through any reliable means, such as the hospital where the child was born, *the medical practitioner, or the mother's managed care organization*. The agency may not require that only the mother make the report.

Do not redetermine eligibility of a child born to a Medicaid-eligible pregnant woman until the month in which the child turns one year old, unless there is any indication that the child is no longer living with the mother.

If the child continues to live with the mother, his/her eligibility continues in the appropriate Newborn Child Under One covered group (CNNMP or MN) until the month he/she turns one. A redetermination must be done *prior to MMIS cut-off in the month* the child turns one year old.

**2. Child Turns  
Age 6**

When a child who is enrolled as an MI child turns age 6, the child's PD in MMIS will automatically be changed to 92 or 94. No action is required when the child is enrolled as PD 92. If the child is enrolled as PD 94, a partial review must be completed to determine if the child has creditable health insurance coverage. If the child does not have creditable health insurance, no additional action is required. If the child has creditable health insurance, the eligibility worker must cancel the child's enrollment in PD 94 effective the end of the month and reinstate coverage in PD 92 effective the first day of the following month. **Do not use change transactions to move a child to or from PD 94.** No notice to the recipient is required as there is no reduction in coverage.

**3. SSI Medicaid  
Recipient  
Becomes a  
Qualified  
Severely  
Impaired  
Individual  
(QSII) –  
1619(b)**

When an SSI Medicaid recipient loses eligibility for an SSI money payment due to receipt of earned income, continued Medicaid eligibility under the Qualified Severely Impaired Individual (QSII) - 1619(b) covered group may exist. A review to determine the individual's 1619(b) status in SVES and *his resource eligibility based on ownership of real property* must be completed. To identify a 1619(b) individual, check the "Medicaid Test Indicator" field on the State Verification Exchange System (SVES) WMVE9068 screen. If there is a code of A, B, or F, the individual has 1619(b) status. The eligibility worker must change the PD to the appropriate PD. No notice to the recipient is required as there is no reduction in coverage.

## **M1520.200 REDETERMINATION REQUIREMENTS**

**A. Policy**

*The agency must redetermine the eligibility of all Medicaid recipients, with respect to circumstances that may change, at least every 12 months. Blindness and disability are considered continuing unless it is reported that the individual is no longer blind or disabled.*

*The first twelve-month review period begins with the month of application for Medicaid. Each subsequent redetermination must be completed by the MMIS cut-off date no later than 12 months following the month of the last redetermination.*

**B. Redetermination  
Process****1. Forms**

*A signed redetermination form is required to request continued coverage for all Medicaid recipients other than those receiving Auxiliary Grants (AG), IV-E foster care (FC), or IV-E adoption assistance (AA). Individuals found eligible for AG or IV-E FC or AA are not required to complete a separate document; however, continued receipt of AG or IV-E status, Virginia residence, and current TPL must be documented.*

*There are specialized application/redetermination forms intended for use with certain covered groups, including children under age 19, SSI recipients, and women who have been screened under the Breast and Cervical Cancer Prevention and Treatment Act (BCCPTA). These forms should be used whenever possible because they do not ask the applicant to provide information that is not used in the eligibility determination.*

*The following forms have been prescribed as redetermination forms for Medicaid:*

- *Application/Redetermination for Medicaid for SSI Recipients, form # 032-03-091 limited to SSI and QSI recipients (see M0120, Appendix 4);*
- *Medicaid Application/Redetermination for Medically Indigent Pregnant Women, form #032-03-040 (see M0120, Appendix 5);*
- *Application for Children's Health Insurance in Virginia, form #FAMIS-1 (see M0120, Appendix 6);*
- *Breast and Cervical Cancer Prevention and Treatment Act (BCCPTA) Medicaid Application/Redetermination, form #032-03-384, (M0120, Appendix 7);*
- *Eligibility Review Part A, form #032-03-729 A and Eligibility Review Part B, form #032-03-729 B;*
- *ADAPT Statement of Facts (SOF);*
- *Medicaid Redetermination For Long-Term Care; form #032-03-369;*
- *Title IV-E Foster Care & Medicaid Application/Redetermination, form #032-03-636 (see M0120, Appendix 8).*



*The document used for the redetermination must collect the information necessary to correctly evaluate the individual's continued Medicaid eligibility. If the recipient is completing a redetermination for another program in ADAPT or the information collected by ADAPT is insufficient to determine Medicaid eligibility (individual requires medically needy eligibility determination), the appropriate pages from an Application for Benefits or the Eligibility Review Part A and Eligibility Review Part B can be used to collect the information. The pages must be signed by the recipient and attached to the SOF.*

*The policy for who can sign a redetermination is the same as the policy for who can sign an application (see M0120.200).*

## **2. Verification**

*An individual's continued eligibility for Medicaid requires verification of income for all covered groups and resources for covered groups with resource requirements.*

*The recipient must be notified in writing of the required verification. The eligibility worker must allow at least 10 days for receipt of the necessary verifications, but additional time may be allowed depending on the type of information requested. The specific information requested and the deadline for receipt of the verification must be documented.*

*If information necessary to redetermine eligibility is requested but not provided by the recipient and cannot be obtained from any other source, the redetermination must be denied and the coverage cancelled due to the inability to determine eligibility.*

## **3. Time Standard**

*Appropriate agency action on the redetermination must be taken no later than the MMIS cut-off in the 12<sup>th</sup> month of eligibility.*

## **C. Special F&C Requirements**

### **1. Pregnant Woman**

A redetermination of eligibility of an MI pregnant woman who applied on or before the end of her pregnancy is not required until 12 months following the end of her pregnancy. Send the advance notice of the reduction in benefits and cancel her full coverage at the end of month in which the 60-day postpartum period or the advance notice period ends, whichever comes later. Reinstate the Family Planning Services limited coverage in the MMIS the first day of the month following the end of the 60-day postpartum period. Do not use change transactions to move an individual between full and limited coverage.

The recipient may request a redetermination to determine if eligibility can be established in another covered group. The Eligibility Review Part A and the Eligibility Review Part B forms can be used if the initial eligibility was determined using an Application for Benefits and no additional nonfinancial information is needed. If initial eligibility was determined using the MI application or additional nonfinancial information is needed, the Application for Benefits or an ADAPT interactive interview can be used to obtain the information necessary to evaluate eligibility.

If she is eligible in a full-benefit covered group change her PD in the MMIS.

**2. Family  
Planning  
Services (FPS)**

The Medicaid eligibility of women in the FPS covered group must be redetermined 12 months following the end of the pregnancy. If the woman remains eligible, she is entitled to an additional 12 months of FPS coverage. The Application for MI Pregnant Women, the Eligibility Review Part A and the Eligibility Review Part B, the ADAPT SOF, or other appropriate forms can be used for the redetermination.

**3. Newborn  
Child Turns  
Age 1**

A redetermination must be done when a newborn child turns age 1 and must include:

- a. evaluation of the child's eligibility in another covered group and completion and signing of the appropriate application (Children's Health Insurance in Virginia, the Eligibility Review Part A and the Eligibility Review Part B, or the ADAPT SOF);
- b. SSN or proof of application;
- c. for an MI child, a review of income;
- d. for an MN child, a review of income and resources.

**4. MI Child  
Under Age 19  
(FAMIS Plus)**

The Medicaid eligibility of children in the MI Child Under Age 19 (FAMIS Plus) covered group must be redetermined at least once every twelve months. The twelve-month review period begins with the month of application for Medicaid. The Children's Health Insurance in Virginia application, the ADAPT SOF, or other appropriate forms can be used for the redetermination.

When an enrolled MI child no longer meets the MI income limits, evaluate the child for the Family Access to Medical Insurance Security Plan (FAMIS) using the eligibility requirements in chapter M21. *A new application/redetermination form is not required when the most recent application/redetermination form that included FAMIS was completed within the past 12 months. If the most recent application/redetermination was filed more than 11 months ago or did not include FAMIS, a new application/redetermination form that includes FAMIS must be completed and evaluated prior to canceling*

*the Medicaid. If the child is eligible for FAMIS, send the family an Advance Notice of Proposed Action that Medicaid will be cancelled effective the last day of the month in which the 10-day advance notice expires and the FAMIS coverage will begin the first day of the month following the Medicaid cancellation. Use cancel reason "42" when the child loses eligibility in Medicaid and is enrolled in FAMIS and there is no break in coverage. **Do not use change transactions to move a child between Medicaid and FAMIS.** If the child is not eligible for FAMIS, the worker must provide an opportunity for the child to be evaluated as medically needy prior to sending an Advance Notice of Proposed Action and canceling the child's Medicaid coverage.*

**5. MI Child  
Turns Age 19**

When an MI child turns age 19, redetermine the child's continuing Medicaid eligibility in other covered groups.

If the child does not meet a definition for another covered group, send an advance notice and cancel the child's Medicaid coverage because the child does not meet a Medicaid covered group.

**6. Child Turns  
Age 21**

When a child who is enrolled as a child under age 21 attains age 21, redetermine continuing Medicaid eligibility under other covered groups.

If the individual meets the definition of another covered group, obtain the information to determine if the individual's resources and income are within the applicable limits for the individual's covered group. The Eligibility Review Part A and the Eligibility Review Part B forms can be used if no additional nonfinancial information is needed. If additional nonfinancial information is needed, an Application for Benefits or an ADAPT interactive interview can be used to obtain the information necessary to evaluate eligibility. If the individual is eligible in another covered group, change the individual's aid category in the MMIS.

If the individual does not meet a definition for another covered group, send an advance notice and cancel the individual's Medicaid coverage because the individual does not meet a Medicaid covered group.

If the individual is not eligible because of income, send an advance notice and cancel the individual's Medicaid coverage because of excess income, and place the individual on a medically needy spenddown.

**7. IV-E FC and  
AA and Special  
Medical Needs  
AA Children  
From Another  
State**

*For FC or AA children placed by another state's social services agency, verification of continued IV-E or non-IV-E special medical needs status, current address, and TPL can be obtained from the parent or the other state.*

**8. Breast and  
Cervical  
Cancer  
Prevention and  
Detection Act  
(BCCPTA)**

*The BCCPTA Application/Redetermination, form #032-03-384 is used to redetermine eligibility for the BCCPTA covered group. The redetermination form is available on-line at [http://www.localagency.dss.state.va.us/divisions/bp/files/me/forms/General/Breast\\_and\\_Cervical\\_Cancer\\_Prevntion-Treatmnt\\_Act\\_032-03-653.pdf](http://www.localagency.dss.state.va.us/divisions/bp/files/me/forms/General/Breast_and_Cervical_Cancer_Prevntion-Treatmnt_Act_032-03-653.pdf). The recipient must provide a statement from her medical provider verifying continued treatment for breast or cervical cancer. There are no Medicaid financial requirements for the BCCPTA covered group.*

**D. Special ABD  
Requirements**

**1. SSI and QSII  
(1619b)  
Recipients**

*For SSI and QSII recipients, the Application/ Redetermination for Medical Assistance (Medicaid) for SSI Applicants/ Recipients, the form #032-02-091 is used for the redetermination. The worker must also verify SSI or 1619b status by inquiring SVES. Document the case record eligibility evaluation form accordingly. If the individual reports ownership of non-exempt real property, all of the recipient's resources must be verified and evaluated.*

**2. QMB, SLMB  
and QDWI**

*The Medicaid eligibility of individuals in the QMB, SLMB, and QDWI covered groups must be redetermined at least once every twelve months. The twelve-month review period begins with the month of application for Medicaid. Use forms the Eligibility Review Part A and the Eligibility Review Part B forms for the redetermination.*

*Eligible QMBs, SLMBs, and QDWIs who have resources that are within the medically needy resource limits are also placed on two 6-month medically needy spenddowns.*

**E. Recipient Becomes  
Institutionalized**

*When an enrolled recipient is admitted to long-term care in a medical facility or is screened and approved for Medicaid waiver services, redetermine the recipient's eligibility as an individual institutionalized in a medical facility, or an individual receiving Medicaid waiver services using the policies and procedures in chapter M14.*

- F. Long-term Care (LTC)** For long-term care recipients, eligibility must be redetermined at least once every twelve months. The DMAS-122 must be updated and sent to the provider or case manager whenever there is a change in income or deductions. The DMAS-122 must be updated at least every 12 months even if the patient's income or deductions do not change. If income and/or patient pay do not change, a currently dated DMAS-122 must be prepared and sent to the provider or case manager when the annual redetermination is completed.
- G. Patients in DMHMRSAS Facilities** Patients in the Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS) facilities may have review applications submitted by DMHMRSAS staff. The DMHMRSAS facilities are listed in M1550.200.
- H. Reports** *Monthly eligibility review (annual redetermination and follow-up review) lists from the MMIS will be generated and made available. These lists will notify eligibility workers of their recipients who are past due for review, currently due for review and due next month. An agency need not maintain a separate card file of eligibility reviews.*

## **M1520.400 MEDICAID CANCELLATION OR SERVICES REDUCTION**

### **M1520.401 NOTICE REQUIREMENTS**

- A. Policy** Following a determination that eligibility no longer exists or that the recipient's Medicaid services must be reduced, the "Advance Notice of Proposed Action" must be sent to the recipient at least 10 days plus one day for mail, before action is taken to cancel or reduce Medicaid coverage. The proposed action becomes effective no earlier than the first day of the month following the 11-day period allowed for receipt of the "Advance Notice of Proposed Action" form.
- Subsequent use of a Medicaid card to which the individual is not entitled could constitute a fraudulent act.

**B. Change Results in  
Adverse Action****1. Services  
Reduction**

When information is secured that results in a reduction of Medicaid services to the recipient or a reduction in the Medicaid payment for the recipient's services (when the patient pay increases), the "Advance Notice of Proposed Action" must be sent to the recipient at least 10 days plus one day for mail, before the adverse action is taken. The adverse action must not be taken, however, if the recipient requests an appeal hearing before the effective date of the action. The DMAS Chief Hearing Officer notifies the local agency of whether the appeal was filed before the action date.

If the recipient requests an appeal hearing before the effective date, the recipient may choose to have eligibility continued at the current level of services until a decision is reached after a hearing. In the event the decision is adverse to the recipient, the amount Medicaid paid on the services being appealed that were received by the recipient during the continuation is subject to recovery by the Department of Medical Assistance Services (DMAS).

Medicaid coverage at the prior level is not continued when a request for appeal is filed on or after the effective date of the action.

**2. Adverse  
Action  
Resulting from  
Computer  
Matches**

When adverse action is taken based on information provided by computer matches from any source, such as IEVS, the Virginia Employment Commission (VEC) or SAVE, notice must be mailed at least ten (10) days before the effective date of the action, excluding the date of mailing and the effective date.

The following chart indicates some of the computer match sources which require a ten (10) day advance notice.

<u>Match Source</u>	<u>Notification Period</u>
Internal Revenue Service (IRS) unearned income files	10 days
Beneficiary and Earnings Data Exchange (Bendex)	10 days
State Data Exchange (SDX)	10 days
Enumeration Verification System (SSN)	10 days
Systematic Alien Verification For Entitlements (SAVE)	10 days
Department of Motor Vehicles (DMV)	10 days
Virginia Employment Commission (VEC)	10 days
Benefit Exchange Earnings Record (BEERS)	10 days

#### **D. Procedures**

##### **1. Action Appealed**

Adverse action must not be taken if the recipient requests an appeal hearing before the effective date of the action. The DMAS Chief Hearing Officer will notify the local agency whether to continue coverage during the appeal.

If the recipient requests an appeal hearing before the effective date, the recipient may choose to have eligibility continued at the current level of services until a decision is reached after a hearing. In the event the decision is adverse to the recipient, the amount Medicaid paid on the services being appealed that were received by the recipient during the continuation is subject to recovery by the Department of Medical Assistance Services (DMAS).

Medicaid coverage is not continued when a request for appeal is filed on or after the effective date of the action.

When notification is received from DMAS that the agency's proposed adverse action was sustained, the recipient's eligibility must be terminated effective the date of the receipt of that letter. No further advance notice to the recipient is necessary since he/she is also informed of DMAS's decision.

- 2. Death of Recipient**

Adequate notice of cancellation must be sent to the estate of the recipient at the recipient's last known address when information is received that the recipient is deceased. The effective date of cancellation in the MMIS computer eligibility file is the date of death.
- 3. End of Spenddown Period**

When eligibility automatically terminates at the end of a six-month spenddown period, advance notice is not required. The limited period of spenddown eligibility is identified on the individual's Medicaid card and on the "Notice of Action on Medicaid" sent at the time the application is approved. Explanation of this limitation and information relative to reapplication is provided at the time of the eligibility determination and enrollment.

## **M1520.402 CANCELLATION ACTION OR SERVICES REDUCTION**

### **A. Introduction**

- 1. MMIS Computer Transaction**

A case must be canceled in the Medicaid computer prior to the date of the proposed action. The change to the MMIS recipient file must be made after cut-off in the month before the month the proposed action is to become effective. For example, if the notice of action specifies the intent to cancel on October 31, a change to the Medicaid computer is made after cut-off in September and before cut-off in October.

In the event the proposed action is not taken or an appeal is filed prior to the proposed date of action, the case must be immediately reopened.

- 2. Reason "12" Cancellations**

When information is received from the Department of Medical Assistance Services that a case is canceled for cancel reason "12", the local social services department must determine if the cancellation is valid. When cancellation is not valid, the case must be re-enrolled immediately.

When the cancellation is valid, the local department must mail the individual an adequate notice of cancellation using the form "Notice of Action on Medicaid." Adequate notice consists of specifying the date the cancel action took place, which is the date the notice is mailed, in the section marked "Other" on the notification form.

## **M1520.403 RECIPIENT REQUESTS CANCELLATION**

A recipient may request cancellation of his Medicaid coverage. The request must be written and documented in the record. When the recipient requests cancellation of Medicaid, the local department must send a Notice of Action on Medicaid form #032-03-008 to the recipient no later than the effective date of cancellation. On the notice, check the "other" block and list the reason as "recipient's request." If action to cancel the case is taken after MMIS cut-off, request the recipient return the Medicaid card to the agency. Cancel Medicaid coverage in the MMIS using the cancel reason "04".



## M1520.500 EXTENSIONS OF MEDICAID COVERAGE

### A. Policy

Medicaid recipients may be eligible for an extended period of Medicaid coverage when the family meets all the requirements for the Low Income Families with Children (LIFC) covered group except income.

LIFC families who received Medicaid in 3 of the last 6 months and who became ineligible for Medicaid due to increased income from child and/or spousal support may be eligible for a 4-month extension.

LIFC families who received Medicaid in 3 of the last 6 months and who became ineligible for Medicaid due to an increase in earnings may be eligible for a 12 months extension. Earnings could increase because of a new job, a raise in the rate of pay or more hours are being worked.

*NOTE: Children must first be evaluated for Medicaid eligibility in the MI Child Under Age 19 (FAMIS Plus) covered group and if eligible, enrolled using the appropriate MI Child Under Age 19 PD. If ineligible as MI, the child must be evaluated for the Medicaid extensions. If ineligible for the Medicaid extensions, the child must be evaluated for FAMIS. If ineligible for FAMIS, the family must be given an opportunity for a medically needy determination prior to the worker taking action to cancel the Medicaid coverage.*

### B. Procedure

The policy and procedures for the four-month extension are in section M1520.501 below.

The policy and procedures for the twelve-month extension are in section M1520.502 below.

## M1520.501 FOUR-MONTH EXTENSION

### A. Policy

An LIFC Medicaid family is entitled to four additional months of Medicaid coverage after they lose Medicaid LIFC eligibility when the following conditions are met:

- The family received Medicaid as LIFC in at least three of the six months immediately preceding the month in which they became ineligible for LIFC;
- The family lost eligibility solely or partly due to receipt of or Increased child or spousal support income; and
- All other Medicaid eligibility factors except income are met.

### B. Procedures

#### 1. Received in Error

For purposes of this subsection, "received Medicaid as LIFC" does not include received Medicaid erroneously. Therefore, a family unit who received Medicaid, erroneously during 3 or more of the 6 months proceeding the month of ineligibility does not qualify for the Medicaid extension.

- 2. New Family Member**

A new member of the family unit is eligible for Medicaid under this provision if he/she was a member of the unit in the month the unit became ineligible for LIFC Medicaid. However, even if a baby was not born as of that month, a baby born to an eligible member of the unit during the 4-month extension is eligible under this provision because the baby meets the categorically needy non-money payment newborn child under age 1 covered group.
- 3. Moves Out of State**

Eligibility does not continue for any member of the family unit who moves to another state.
- 4. Coverage Period**

Medicaid coverage will continue for a period of four months beginning with the month in which the family became ineligible for LIFC Medicaid because of support income.
- 5. Program Designation**

Cases eligible for this four-month extension are categorically needy non-money payment. A Medicaid-Only application and case are recorded statistically. The program designation for the recipients in the unit remains "81" or "83."
- 6. Case Handling**

Those cases closed in a timely manner must be held in a suspense file until the fourth month after the LIFC Medicaid cancellation month. At that time, action must be taken to evaluate continuing Medicaid eligibility.

If all eligibility factors are met, the children in the case may continue eligible as MI or medically needy. Make the appropriate program designation changes to the computer file.

The caretaker's Medicaid coverage must be canceled if he/she does not meet a Medicaid covered group. An appropriate "Advance Notice of Proposed Action", form 032-03-018 must be sent to the recipient if the caretaker or the case is no longer eligible for Medicaid.

## **M1520.502 TWELVE-MONTHS EXTENSION**

- A. Policy**
- An LIFC Medicaid family is entitled to six additional months, with possible extension to twelve months, of Medicaid coverage after they lose Medicaid LIFC eligibility when the following conditions are met.
- The family consists of those individuals living in the household whose needs and income were included in determining the LIFC Medicaid eligibility of the assistance unit at the time that the LIFC Medicaid eligibility terminated. It also includes family members born, adopted into, or returning to the family after extended benefits begin who would have been considered a member of the unit at the time the LIFC Medicaid eligibility terminated.
- The earned income of family members added after the family loses LIFC Medicaid eligibility must be counted to determine gross family income.

## **M1520.600 CASE TRANSFERS**

- A. Introduction**      Applications and ongoing cases are transferred only when the individual retains residence in Virginia.
- B. Nursing Facility and Assisted Living Facility (ALF)**      When an applicant/recipient is admitted to a nursing facility or an ALF from a community living arrangement, the case is not transferred, but remains with the Virginia locality in which the individual last lived outside of an institution. Community living arrangements do not include medical facilities, ALFs or group homes with four or more beds.
- When an applicant/recipient is discharged from a nursing facility or ALF to a community living arrangement not in the Virginia locality that had responsibility for the individual's case while he was in the nursing facility or ALF, the case is transferred to the new locality.
- C. DMHMRSAS Facilities**      The procedures for transfer of Medicaid cases of ABD patients admitted to or discharged from DMHMRSAS facilities are in subchapter M1550. F&C cases are not transferred.
- D. DMAS Medicaid Unit-FIPS 976**      The Medicaid cases approved by the DMAS Medicaid unit, FIPS 976, must be transferred to the local agency where the recipient lives. The receiving agency must confirm receipt of the case by completing the Case Record Transfer Form and returning the copy to the DMAS Medicaid unit. Cases from the DMAS Medicaid unit do not require a redetermination until the annual redetermination is due.
- Medicaid cases are not transferred from local agencies to FIPS 976.
- E. Locality to Locality**      When a Medicaid applicant/recipient (including a Medicaid CBC waiver services recipient) moves from one locality to live in a community living arrangement (not a medical facility, an ALF, or a group home with 4 or more beds) in another locality within the State of Virginia, the following procedures apply:
- 1. Sending Locality Responsibilities**      The sending locality (the locality from which the recipient has moved) must review the case immediately and make an evaluation, based on known information, as to whether or not the recipient will meet a covered group and the income and resource limits in the new locality.
- If the desk review finds that eligibility no longer exists, the agency must take the necessary action, including advance notice to the individual, to cancel coverage and to cancel the case in the MMIS.
- If the desk review indicates that the recipient will continue to be eligible for Medicaid in the new locality, the sending locality must update the MMIS

with the new address and city/county code so that the new locality can accept the case for transfer. The *sending locality* must prepare the "Case Record Transfer Form" and forward it, with the case record, to the department of social services in the new locality of residence.

Pending applications must be transferred to the new locality for an eligibility determination.

*Foster care and adoption assistance Medicaid cases are not transferred unless custody or responsibility for services and/or payment is transferred.*

The eligibility record must be sent by certified mail, delivered personally and a receipt obtained or at the agency's discretion the case may be sent via the courier pouch.

**2. Receiving  
Locality  
Responsibilities**

The receiving agency (the DSS agency in the locality to which the recipient moves) must redetermine the recipient's circumstances in his new locality. The agency must redetermine the recipient's eligibility as soon as administratively feasible, but no later than the second month after the month in which a transfer request is received. The receiving agency must confirm receipt of the case by completing the Case Record Transfer Form and returning the copy to the sending agency.

If the eligibility redetermination by the receiving agency finds that eligibility no longer exists, that agency must take the necessary action, including sending advance notice to cancel coverage and canceling the case in the MMIS.

When a pending application is transferred, the receiving agency makes the eligibility determination and takes all necessary action, including sending the notice and enrolling eligible individuals in the MMIS.

**F. Spenddown Cases**

Cases in spenddown status (denied or canceled and placed on a spenddown) must be transferred when the applicant notifies the agency that he/she has moved to a new Virginia locality.

**1. Sending  
Locality  
Responsibilities**

Within 10 working days of notification that the applicant has moved, the case must be transferred to the new locality, using the "Case Record Transfer Form." The sending agency must:

- inform the applicant of the receiving agency's name, address, and telephone number;
- deduct all known spenddown items from the spenddown balance on the worksheet before sending the case record;
- note the spenddown period and balance on the case transfer form.

**2. Receiving  
Locality  
Responsibilities**

The receiving locality logs the case record on file, but does not open it statistically. The receiving locality must review the spenddown to determine if a recalculation based on a different income limit is required.

If the spenddown is met, the application is recorded statistically as taken, approved, and added to the caseload at that time.

- e) the recipient's Medicaid coverage is automatically canceled by the Medicaid computer. An advance notice from the local agency is required if the recipient becomes ineligible before the projected month of automatic cancellation. Medicaid is automatically canceled when the recipient no longer meets the category's age limit or pregnancy duration limit, when the 12-month extension or transitional period ends, or when the recipient does not return the earnings report in a timely manner.

### 3. Cancellation due to death

The "Notice of Action on Medicaid" form must be sent to a recipient's estate at the recipient's last known address, or to his authorized representative, when coverage is terminated as a result of the recipient's death. The effective date of cancellation must be the date of death.

## M1620.100 LOCAL AGENCY CONFERENCE

### A. Time Limits

A dissatisfied applicant or recipient must be given the opportunity to request a local agency conference. The conference must be scheduled within 10 working days of receiving a request for a conference.

### B. Conference Procedures

At the conference, the applicant/recipient must be:

- given an explanation of the action.
- allowed to present any information to support his disagreement with the action.
- allowed to represent himself or be represented by an authorized representative such as a legal counsel, friend, or relative.

### C. Failure to Request a Conference

The applicant's or recipient's failure to request a conference does not affect his right to appeal to the State agency within 30 days and does not affect his right to continued eligibility if he appeals a proposed cancellation, *patient pay increase, or reduction of benefits from full coverage to limited coverage* prior to the effective date of the action.

### D. The Conference/ Right to Appeal

The local agency conference must not be used to interfere with the appellant's right to a fair hearing before the State Department of Medical Assistance Services.

### E. Decision Notification

1. The local agency conference may or may not result in a change in the agency's decision to take the action in question.
2. If the agency's decision is not to take the action indicated on the "Notice of Action on Medicaid" or on the "Advance Notice of Proposed Action", the applicant or recipient must be so advised in writing and a notation of the changed action must be entered on the agency copy of the notice. *A copy of the amended notice must be sent to DMAS.*

3. If the agency's decision is to stand by its action, the recipient must be so advised but written notice of this decision is not required.

**F. Right to Appeal  
Conference  
Decision**

If the recipient is not satisfied with the agency action following the conference and wants to request a fair hearing before the State agency, he must be given that opportunity and be given any needed assistance to file an appeal.

**G. Reversal of  
Decision Prior to  
Appeal Decision**

An agency can reverse its decision to deny, *reduce*, or terminate Medicaid at any time between making the original decision and when a decision is rendered by the Hearing Officer. Such a change may occur due to receipt of previously unavailable or unknown information, or reevaluation of the case circumstances. If the agency changes its decision, the applicant/recipient and the Hearing Officer must be notified in writing of the change. Send a copy of the notice to the Hearing Officer.

**M1630.100 CONTINUED COVERAGE PENDING APPEAL DECISION**

**A. Coverage May  
Continue**

When an appeal is received and validated, the DMAS Appeals Division decides if Medicaid coverage must continue and notifies the agency. The agency should not continue coverage due to the appeal until it has been contacted by the Appeals Division. Upon being informed, by telephone or correspondence, that the appellant is eligible to receive continued coverage, the agency must reinstate coverage immediately.

A recipient's Medicaid coverage must continue until a final appeal decision is made when an appeal hearing is requested prior to the effective date of the action stated on the "Advance Notice of Proposed Action" or the "Notice of Obligation for Long Term Care Costs".

**B. Coverage Not  
Continued**

Coverage will not continue until the final appeal decision when:

1. an appeal hearing is requested on or after the effective date of action;
2. an appellant does not dispute the facts used by the local agency, but is appealing the policy on which the agency based its action;
3. at the hearing, the Hearing Officer determines that the sole issue of the appeal is disagreement with existing State or Federal policy or law and that no facts are disputed. The Hearing Officer will *promptly* notify the appellant or his representative and the agency in writing that continued Medicaid coverage must terminate immediately. The agency shall terminate the recipient's Medicaid immediately, using cancel reason "15" effective the date of the hearing.

**C. Recovery of  
Continued  
Coverage Costs**

When the Hearing Officer upholds the agency's determination, the cost of medical care received during the period of continued coverage may be recovered by the DMAS. (See M1670.100)

## M1640.100 APPEAL REQUEST PROCEDURES

- A. Appeal Definition**
1. An appeal is a request for a fair hearing. The request must be a clear, *signed* written expression by an applicant or recipient, his legal representative (such as a guardian, conservator, or person having power of attorney), or his authorized representative acting at his request, of a desire to present his case to a higher authority.
  2. The appeal request must be written. It may be a letter or a completed "Medicaid/SLH/FAMIS Appeal Request Form."
- B. Where to File an Appeal**
- Appeals must be sent to the Department of Medical Assistance Services, Appeals Division, 600 East Broad Street, Suite 1300, Richmond, Virginia 23219.
- C. Assuring the Freedom to Appeal**
- The freedom of appeal must not be limited or interfered with in any way. When requested to do so, the agency shall assist the appellant in preparing and submitting his request for a fair hearing.
- D. Appeal Time Standards**
1. A request for a hearing must be made within 30 days of receipt of notification that an application for medical assistance is denied, that it has not been acted upon with reasonable promptness, that a request for a medical service has been denied, or that the agency proposes to take any other action that will adversely affect receipt of medical assistance.
  2. Notification is presumed received by the applicant/recipient within three days of the date the notice was mailed, unless the applicant/recipient substantiates that the notice was not received in the three-day period through no fault of his/her own.
  3. The DMAS will, at its discretion, grant an extension of the time limit for requesting a fair hearing if failure to comply with the time limit is due to a good cause such as illness of the appellant or his representative, failure to have been notified of the right to appeal, delay due to the postal service or to an incorrect address, or other unusual or unavoidable circumstances.
- E. Appeal Validation**
1. Following receipt of a written request for a hearing, the DMAS Appeals Division will determine whether the request is valid and will notify the appellant of the status of the appeal. A valid appeal is one that appeals an action over which the DMAS has hearing authority, and that is received within the required time limit or extended time limit. During the process of validating an appeal request, a representative of the DMAS may contact the agency to request a copy of the notice of the adverse action. Upon receipt of such a request, the agency must immediately send a copy of the notice to the DMAS Appeals Division.

2. When an appeal is found valid, the DMAS will notify the appellant and request an appeal summary from the appropriate local agency.

## **M1650.100 LOCAL AGENCY APPEAL SUMMARY**

### **A. Procedures**

Once an appeal of an agency action has been validated, the agency must complete an "Agency Appeal Summary," form #032-03-805 (see Appendix 1 to this chapter). At least ten days prior to the hearing, the agency must send one copy of this form to each of the following:

1. Department of Medical Assistance Services, Appeals Division, 600 East Broad Street, Suite 1300, Richmond, Virginia 23219.
2. The local agency's assigned Medicaid Program *Consultant*.
3. The appellant or his authorized representative.

The agency must keep a copy of the appeal summary for its records.

## **M1660.100 THE HEARING PROCEDURE**

### **A. The Hearing Officer**

A qualified, impartial representative of the DMAS will conduct the hearing. This individual, the Hearing Officer, must not have been directly involved in the initial decision being appealed. The Hearing Officer will schedule the hearing at a time, date, and place convenient to the appellant and the involved agency. Some hearings may be held telephonically.

### **B. Hearing Procedure**

To best serve the appellant's interest, the hearing will be conducted in an informal manner. Formal rules of evidence do not apply in these proceedings. The appellant is entitled to guarantees of fair hearings established in Goldberg v. Kelly, 397 US 245 (1970). The proceedings



will be governed by the following rules:

1. *The Hearing Officer* will swear-in all hearing participants who will be presenting evidence or facts, and will record the hearing proceedings.
2. The appellant will present his own case or have it presented by an authorized representative. He will be allowed to bring witnesses, establish all pertinent facts and circumstances, advance any testimony or evidence, and question witnesses.
3. The appellant or his representative must be given the opportunity to examine all documents and records to be used at the hearing, at a time before the hearing or during the hearing. Copies of case record information must be made available free of charge to the appellant at his request.

**C. Hearing Officer  
Evaluation and  
Decision**

**1. Evaluation**

Following the hearing, the Hearing Officer prepares a decision taking into account the summary prepared by the agency or medical provider involved, evidence provided by the appellant or his representative, and additional information provided by the agency or gathered by the Hearing Officer. The Hearing Officer evaluates all evidence, researches laws, regulations and policy, and decides on the correctness of the action being appealed.

**2. Procedures**

If the local department of social services denies an application because of failure to provide requested information, the hearing will address:

- a. whether or not the applicant was given appropriate notification of what was needed for the eligibility determination; and
- b. whether or not the applicant was given sufficient time to submit the information requested.

If the local department of social services followed correct procedures (*see M0130.200*) and the applicant brings the requested information to the hearing, the action of the local department of social services will be sustained and the applicant will be required to file a new application.

If the hearing officer determines that the local department of social services did not follow appropriate procedures, the case may be remanded for appropriate action.

If the hearing officer determines that the local department of social services did not follow correct procedures, and the applicant brings the relevant information to the hearing, the case may be remanded for an eligibility determination using the original application date.

**3. Hearing  
Officer  
Decision**

Examples of the Hearing Officer's decisions include but are not limited to, sustaining the agency action, reversing the agency action or remanding the case to the agency for additional evaluation.

- |         |  |
|---------|--|
| Sustain | The Hearing Officer's <i>decision</i> upholds the agency's action.   |
| Reverse | The Hearing Officer's decision overturns the agency's decision.  |
| Remand  | The Hearing Officer's decision sends the case back to the agency for additional evaluation. The Hearing Officer's decision will include specific instructions that must be followed when completing the remand evaluation. |

Upon examination of the summary submitted by the local agency, if it is determined that an obvious error or misunderstanding of policy has occurred *and that the case should be resolved in the applicant's favor*, the Hearing Officer has the authority to issue a judgement on the record instead of holding a hearing. The Hearing Officer will provide the local agency with a clear explanation of the reason(s) for issuing a judgement on the record and which actions must be taken by the local agency to correct the case. The decision to issue a judgement on the record is at the Hearing Officer's discretion.

**D. Local Agency  
Action**

The decision of the Hearing Officer is the final administrative action taken on the appeal. The local agency must comply with the Hearing Officer's decision. If the Hearing Officer's decision is to remand the case to the local agency, the local agency must not send documentation of the evaluation or a copy of the remand notice to the Hearing Officer.

**1. Agency  
Action -  
Sustained  
Cases**

Following a Hearing Officer's decision that a proposed agency action to cancel coverage is sustained, the case must be closed without an additional notice to the recipient from the local agency. The Hearing Officer's decision letter to the appellant is the appropriate official notice of cancellation. The local agency must take action to close the case in the Medicaid computer using cancel reason "15" effective the date the agency receives the decision.

**2. Agency  
Action-  
Remand Cases**

- a. If the Hearing Officer's decision is to remand the case for further evaluation and coverage was continued during the appeal process, coverage must be continued until the local agency completes the evaluation and makes a new decision.
- b. If the remand evaluation results in the appellant's continuous eligibility, the local agency must notify the appellant of his/her continuing eligibility for coverage.
- c. If the remand evaluation results in the appellant's continuous eligibility and coverage was not continued during the appeal process, the local agency must reinstate coverage back to the original termination date (no break in coverage) and notify the appellant of

PAGE 6 (SUPPLEMENTAL)

SECTION V: "MEDICALLY RELATED APPEALS" INFORMATION

DATE OF APPLICATION OR REVIEW: \_\_\_\_\_

DATE MEDICAL HISTORY & DISABILITY  
REPORT SUBMITTED TO MDU: \_\_\_\_\_DATE DISABILITY REFERRAL FORM  
SUBMITTED TO MDU: \_\_\_\_\_

MDU RESULTS: \_\_\_\_\_

WERE DISABILITY EXCEPTIONS EVALUATED? BY WHOM? INDICATE RESULTS OF  
EVALUATION:

---

---

---

---

DATE OF SSA/SSI DECISION: \_\_\_\_\_

IS APPLICANT CURRENTLY RECEIVING SSA/SSI? \_\_\_\_\_

LIST ALL OTHER CATEGORIES EVALUATED AND INDICATE WHY THEY WERE NOT MET  
OR DO NOT APPLY:

---

---

---

---

DATE OF PERSONAL CARE OR MEDICAL MANAGEMENT NOTICE: \_\_\_\_\_

WAS AGENCY WORKER DIRECTLY INVOLVED IN DECISION? RESULTS OF  
PARTICIPATION:

---

---

---

ATTACH COPIES OF MEDICAL HISTORY AND DISABILITY REPORT, DISABILITY REFERRAL  
FORM, PERSONAL CARE, MEDICAL MANAGEMENT, AND ANY SSA/SSI NOTICES AND  
DECISIONS.

## AGENCY APPEAL SUMMARY

FORM NUMBER - 032-03-805

PURPOSE OF FORM - To provide information to DMAS about case when an action of an eligibility worker on a Medicaid, SLH, or *FAMIS* case is being appealed.

NUMBER OF COPIES - See detailed instructions below.

DISPOSITION OF FORM - See detailed instructions below.

INSTRUCTIONS FOR PREPARATION OF FORM - To print this form, first print position should be 5, line spacing should be b, and pitch should be 12. See detailed instructions below for completing the form.

1. The "Agency Appeal Summary" must be prepared by the individual who took action on the case. If that individual is not available to complete the summary, it must be so stated, with an explanation provided.
2. Answer all questions in the "case identification" and "general information" sections and all questions in the section relating to the specific issue(s) of the appeal. If a pre-hearing conference is held, details of the conference should be included in the summary. If a question is not applicable, so indicate by N/A.
3. Any page or section of the "Agency Appeal Summary" form which is not relevant to the appeal should be omitted. The form may be typed, computerized, or handwritten, but cannot be altered or modified in any form.
4. The worker can complete a narrative summarizing the information contained in the other parts of the summary, and containing relevant background information pertinent to the case action. This may assist the local DSS representative in presenting testimony at the hearing.
5. Show all calculations used to reach values upon which the action was based. Computations should be shown in the "Agency Appeal Summary", on a separate sheet, or may be added to the bottom of the narrative.
6. On appeals in which the action was taken by another agency, and the local DSS only provided appropriate notices to the claimant or evaluated the "disability exceptions", the worker is required to complete only the "case identification" and "general information" sections of the summary and the "medically related" section relevant to the action taken by the local DSS.
7. Attach copies of all relevant documentation and verifications, including (but not limited to), those listed in the "general eligibility" section of the "Agency Appeal Summary". It is not necessary to label attachments for identification on the document. Exhibit labeling will be done by the hearing officer. A cover sheet identifying attachments is sufficient.

8. Distribute copies of the "Agency Appeal Summary" following the instructions in the "Agency Request" letter to the following:

- (1) the claimant and his/her representative,
- (2) the *local agency's assigned Medicaid Program Consultant, and*
- (3) Department of Medical Assistance Services  
Division of Client Appeals  
600 East Broad Street, Suite 1300  
Richmond, Virginia 23219

Note: The claimant's entire case record must be available to the claimant and his/her representative. If the case record contains medical records marked "Confidential", restricting patient access, do not provide claimant access to those records without written authorization of the physician.

## TABLE OF CONTENTS

### M21 – FAMILY ACCESS TO MEDICAL INSURANCE SECURITY PLAN (FAMIS)

	Section	Page
FAMIS General Information .....	M2110.100 .....	1
Nonfinancial Eligibility Requirements.....	M2120.100 .....	2
Health Insurance Coverage.....	M2120.200 .....	4
No Child Support Requirements .....	M2120.300 .....	8
Financial Eligibility.....	M2130.100 .....	8
Application and Case Procedures.....	M2140.100 .....	8
Review of Adverse Actions.....	M2150.100 .....	11

### APPENDICES

FAMIS Income Limits.....	Appendix 1 .....	1
Local Choice Program Active Groups .....	Appendix 2 .....	1
Virginia State Agency List .....	Appendix 3 .....	1
Application for Children’s Health Insurance in Virginia .....	Appendix 4 .....	1
Family Access to Medical Insurance Security Plan (FAMIS) Supplemental Application Form.....	Appendix 5 .....	1
Children’s Health Insurance Communication Form .....	Appendix 6 .....	1
<i>FAMIS Alien Eligibility Chart</i> .....	<i>Appendix 7</i> .....	<i>1</i>

## **M2100.000 FAMILY ACCESS TO MEDICAL INSURANCE SECURITY PLAN (FAMIS)**

### **M2110.100 FAMIS GENERAL INFORMATION**

#### **A. Introduction**

The Balanced Budget Act of 1997 created the State Children's Health Insurance Program, enacted as Title XXI of the Social Security Act, to provide funds to States to enable them to initiate the provision of child health insurance to **uninsured low-income children**.

FAMIS is not an entitlement program, which means that if funds for this program are exhausted, no additional individuals will receive benefits under the program. The Department of Medical Assistance Services (DMAS) will notify the Department of Social Services (DSS) Central Office if funds for this program run out.

Initial eligibility for FAMIS is determined by local DSS, including DSS outstationed sites, or by the FAMIS Central Processing Unit (CPU). Children found eligible for FAMIS receive benefits described in the State's Title XXI Child Health Insurance Program. Eligible children are enrolled for benefits effective the first day of the child's application month if all eligibility requirements are met in that month, but no earlier than the date of the child's birth. There is no retroactive coverage in FAMIS. Case management and ongoing case maintenance, and selection for managed care are handled by the FAMIS CPU.

#### **B. Legal Base**

The 1998 Acts of Assembly, Chapter 464, authorized Virginia's Children's Health Insurance Program by creating the Children's Medical Security Insurance Plan for uninsured children under 19 years of age. In August 2001, the program was revised and renamed the Family Access to Medical Insurance Security Plan (FAMIS).

#### **C. Policy Principles**

FAMIS covers uninsured low-income children under age 19 who are not eligible for Medicaid and whose gross family income is less than or equal to 200% of the federal poverty level (FPL) for the family size (see M2130.100 for the definition of the FAMIS assistance unit and Appendix 1 for the income limits).

A child is eligible for FAMIS if all of the following are met:

- he is **not** eligible for Medicaid due to excess income;
- he is under age 19 and a resident of Virginia;
- he is uninsured;
- he is **not** a member of a family eligible for health benefits coverage under the State Employee Health Insurance Plan on the basis of a family member's employment with a State agency or a local governmental agency that participates in the Local Choice Program and contributes to the cost of dependent health insurance (see Appendix 2 and Appendix 3 to this chapter);
- he is **not** a member of a family who has dropped health insurance coverage on him within 4 months of the application without good cause;
- he is **not** an inmate of a public institution;
- he is **not** an inpatient in an institution for mental diseases;
- he meets the Medicaid Nonfinancial Eligibility Requirements in Chapter M02 with certain exceptions; and
- he has gross family income less than or equal to 200% FPL.

## **M2120.100 NONFINANCIAL ELIGIBILITY REQUIREMENTS**

### **A. Introduction**

The child must meet, with certain exceptions, the Medicaid Nonfinancial Eligibility Requirements in chapter M02 and the nonfinancial eligibility requirements imposed by FAMIS.

### **B. M02 Requirements**

The Medicaid Nonfinancial Eligibility Requirements in Chapter M02 that must be met are:

- citizenship and alienage requirements;
- Virginia residency requirements;
- institutional status requirements regarding inmates of a public institution.



C. M02 Exceptions

The exceptions to the Medicaid Nonfinancial Eligibility Requirements in Chapter M02 are:

1. Alienage Requirements

*FAMIS alienage requirements are different from the Medicaid alienage requirements. Citizens and qualified aliens who entered before August 22, 1996 meet the citizenship/alienage requirements and are not subject to time limitations.*

*a. The following qualified aliens who entered on or after August 22, 1996 meet the alienage requirements **without regard to time limitations**:*

- *refugees (see M0220.310 A. 2),*
- *asylees ( see M0220.310 A. 4),*
- *veteran or active military (see M0220.311),*
- *deportation withheld (see M0220.310 A. 6), and*
- *victims of a severe form of trafficking (see M0220.313 A.52)*

*b. The following qualified aliens who entered on or after August 22, 1996 meet the alienage requirements **after 5 years of residence in the United States**:*

- *lawful permanent residents (LPR),*
- *conditional entrants-aliens admitted pursuant to 8 U.S.C.1153(a)(7),*
- *aliens paroled in the US pursuant to 8 U.S.C. 1182(d)(5), section 212(d)(5) of the INA, and*
- *battered aliens, alien parents of battered children, alien children of battered parents.*

*Unqualified aliens, including illegal and non-immigrant aliens, do not meet the alienage requirements.*

*Appendix 7, FAMIS Alien Eligibility Chart, lists alien groups that meet or do not meet the alienage requirements.*

2. SSN

A Social Security Account Number (SSN) or proof of application for a SSN (M0240) is **not** a requirement for FAMIS.

3. Assignment of Rights

The child's parent or legal custodian must meet the requirements for the assignment of rights to payment for medical care from any liable third party.

4. HIPP

Application requirements for the Health Insurance Premium Payment (HIPP) program (M0290) do not apply to FAMIS.

**D. FAMIS  
Nonfinancial  
Requirements**

The child must meet the following FAMIS nonfinancial requirements:

**1. Age  
Requirement**

The child must be under age 19. No verification is required.

The child no longer meets the age requirements for FAMIS as of the end of the month in which the child reaches age 19.

**2. Uninsured  
Child**

The child must be uninsured, that is, he must not be covered under any health insurance plan offering hospital and medical benefits. See M2120.200.

**3. State Employee/  
Local Choice  
Prohibition**

A child is ineligible for FAMIS if he is a member of a family eligible for health insurance coverage under any Virginia State Employee Health Insurance Plan on the basis of the family member's employment with a State agency. A child is also ineligible for FAMIS if he is a member of a family eligible for health benefits coverage on the basis of a family member's employment with a local governmental agency that participates in the Local Choice Program and the employer contributes to the cost of dependent health insurance.

**4. IMD  
Prohibition**

The child cannot be an inpatient in an institution for mental diseases (IMD).

**M2120.200 HEALTH INSURANCE COVERAGE**

**A. Introduction**

The intent of FAMIS is to provide health coverage to low-income uninsured children. Eligibility for this program is prohibited when creditable health insurance coverage is dropped within 4 months of the application for FAMIS unless good cause for discontinuing the insurance is demonstrated. Acquisition of health coverage for a child during enrollment in FAMIS is cause for termination.

**B. Definitions**

**1. Creditable  
Coverage**

For the purposes of FAMIS, creditable coverage means coverage of the individual under any of the following:

- church plans and governmental plans;
- health insurance coverage, either group or individual insurance;
- Medicare;
- military-sponsored health care;
- a state health benefits risk pool;
- the federal Employees Health Benefits Plan;
- a public health plan; and
- any other health benefit plan under section 5(e) of the Peace Corps Act.

The definition of creditable coverage includes short-term limited coverage.

- 2. Employer Sponsored Dependent Health Insurance** Employer sponsored dependent health insurance (ESHI) means the employer pays a portion of the premium payment. COBRA coverage in which the employer makes no contribution to the payment of the premium is not employer sponsored insurance.
- 3. Family Member** When determining whether the child is eligible for coverage under a State Employee Health Insurance Plan, family member means parent(s), and a stepparent with whom the child is living if the stepparent claims the child as a dependent on his federal tax return.
- 4. Health Benefit Plan** “Health benefit plan” is defined in the Virginia Bureau of Insurance Regulations (14VAC5-234-30) and means:
- “any accident and health insurance policy or certificate,
  - health services plan contract,
  - health maintenance organization subscriber contract,
  - plan provided by a Multiple Employer Welfare Arrangement (MEWA)”.
- Health benefit plan does not mean:
- accident only;
  - credit or disability insurance;
  - long-term care insurance;

- dental only or vision only insurance;
- specified disease insurance;
- hospital confinement indemnity coverage;
- limited benefit health coverage;
- coverage issued as a supplement to liability insurance;
- insurance arising out of workers' compensation or similar law;
- automobile medical payment insurance; or
- insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

**5. Insured**

means having creditable health insurance coverage or coverage under a health benefit plan.

**6. Uninsured**

means having no insurance; having insurance that is not creditable; having coverage which is not defined as a health benefit plan, or *having a health insurance plan that does not have a network of providers in the area where the child resides.*

**C. Policy**

A nonfinancial requirement of FAMIS is that the child be uninsured. A child **cannot**:

- have creditable health insurance coverage;
- have coverage under a group health plan (Medicare Part A or B, CHAMPUS, federal employee benefit plan, private group insurance such as Trigon, etc.);
- be a member of a family eligible for health benefits coverage under a State Employee Health Insurance Plan (a full-time, salaried, classified State employee or a permanent, full-time, salaried State education institution faculty member) [see Appendix 3 to this chapter];
- be a member of a family eligible for health benefits coverage on the basis of a family member's employment with a public agency in the State that participates in the Local Choice Program and the employer contributes to the cost of dependent health insurance (see Appendix 2 to this chapter), or
- without good cause, have had creditable health insurance coverage terminated within *4 months prior to the month of application.*

Good cause reasons are listed in E. below.

**D. Health  
Insurance  
Coverage  
Discontinued**

A child is ineligible for FAMIS coverage if his creditable health insurance coverage was terminated without good cause within *4 months prior to the month for which eligibility is being established*.

**Example:** A child's health insurance was terminated without good cause November. A FAMIS application was filed the following February. The child is ineligible for February because his health insurance was terminated within 4 months of November. He could be eligible for March as the insurance was terminated more than 4 months prior to March.

NOTE: For purposes related to FAMIS eligibility, a child is NOT considered to have been insured if health insurance coverage was provided under Medicaid, HIPP, FAMIS, or if the insurance plan covering the child does not have a network of providers in the area where the child resides.

**E. Good Cause for  
Dropping Health  
Insurance**

The ineligibility period can be waived if there is good cause for the discontinuation of the health insurance. A parent, guardian, legal custodian, authorized representative, or adult relative with whom the child lives may claim to have good cause for the discontinuation of the child(ren)'s health insurance coverage. The local agency will determine that good cause exists and waive the period of ineligibility if the health insurance was discontinued for one of the following reasons:

- The family member who carried insurance changed jobs or stopped employment, and no other family member's employer contributes to the cost of family health insurance coverage. Verification is not required.
- The employer stopped contributing to the cost of family coverage and no other family member's employer contributes to the cost of family health insurance coverage. Verification is not required.
- The child's coverage was discontinued by an insurance company for reasons of uninsurability, e.g. the child has used up lifetime benefits or the child's coverage was discontinued for reasons unrelated to payment of premiums. Verification is required from the insurance company.
- Insurance was discontinued by a family member who was paying the full cost of the insurance premium under a COBRA policy AND no other family member's employer contributes to the cost of family health insurance coverage. Verification is not required.
- Insurance on the child is discontinued by someone other than the child (if 18 years of age), or, if under age 18, the child's parent or stepparent, e.g. the insurance was discontinued by the child's grandparent, aunt, uncle, godmother, etc. Verification is not required.
- Insurance on the child is discontinued because the cost of the premium exceeds 10% of the family's GROSS monthly income or exceeded 10% of the family's GROSS monthly income at the time the insurance was discontinued.

<b>FAMILY ACCESS TO MEDICAL INSURANCE SECURITY PLAN (FAMIS) INCOME LIMITS ALL LOCALITIES EFFECTIVE 2/13/04</b>				
# of Persons in FAMIS Assistance Unit	FAMIS 150% FPL		FAMIS 200% FPL	
	Annual Limit	Monthly Limit	Annual Limit	Monthly Limit
1	\$13,965	\$1,164	\$18,620	\$1,552
2	18,735	1,562	24,980	2,082
3	23,505	1,959	31,340	2,612
4	28,275	2,357	37,700	3,142
5	33,045	2,754	44,060	3,672
6	37,815	3,152	50,420	4,202
7	42,585	3,549	56,780	4,732
8	47,355	3,947	63,140	5,262
each add'l person add	4,770	398	6,360	530



# Children's Health Insurance

This is an application for FAMIS and FAMIS Plus, Virginia's health insurance programs for children under age 19. Instructions are attached.

Application is: \_\_\_\_\_ a new application  
to continue insurance  
Family ID # \_\_\_\_\_

Office Use Only: Case \_\_\_\_\_  
Worker \_\_\_\_\_

## Step 1 Information on the person completing the application:

Tell us who you are, where you live and where you get your mail.

First Name	MI	Last Name	Phone Numbers	Preferred Language? (See instructions)
			H ( ) W ( )	
Address		Apt No.	City	State
(Street)				
(Mailing)				
			ZIP	City/County of Residence

## Step 2 Information on Children:

Tell us about **all** the children under age 21 living in your home. If there are more than four children in the home, please complete steps 2 and 3 on another application (or on an Additional Child Form) and attach it to this application.

	Child 1	Child 2	Child 3	Child 4
Child's Full Name (Name: First, MI, Last)				
Relationship to You				
Date of Birth & Sex	____/____/____ <input type="checkbox"/> M <input type="checkbox"/> F	____/____/____ <input type="checkbox"/> M <input type="checkbox"/> F	____/____/____ <input type="checkbox"/> M <input type="checkbox"/> F	____/____/____ <input type="checkbox"/> M <input type="checkbox"/> F
Child's Parent or Stepparent Living In the Home (Name: First, MI, Last)	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Stepparent (SS#) _____ Not Required	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Stepparent (SS#) _____ Not Required	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Stepparent (SS#) _____ Not Required	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Stepparent (SS#) _____ Not Required
Child's Parent or Stepparent Living In the Home (Name: First, MI, Last)	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Stepparent (SS#) _____ Not Required	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Stepparent (SS#) _____ Not Required	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Stepparent (SS#) _____ Not Required	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Stepparent (SS#) _____ Not Required

## Step 3

## Information on Children Applying for Insurance:

	Child 1 <i>continued</i>	Child 2 <i>continued</i>	Child 3 <i>continued</i>	Child 4 <i>continued</i>
Child's Full Name (Name: First, MI, Last)				
Applying for Health Insurance for Child?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
<b>If you are applying for insurance for this child, answer the questions below. If you are <u>not</u> applying for this child, you may leave them blank.</b>				
Is Child a US Citizen?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
	If <b>No</b> , Please Fill in the Following Information: Alien/INS # _____ Country of Birth _____ Date Entered _____	If <b>No</b> , Please Fill in the Following Information: Alien/INS # _____ Country of Birth _____ Date Entered _____	If <b>No</b> , Please Fill in the Following Information: Alien/INS # _____ Country of Birth _____ Date Entered _____	If <b>No</b> , Please Fill in the Following Information: Alien/INS # _____ Country of Birth _____ Date Entered _____
Child Social Security # or Date of Application for SS#	(SS#) _____	(SS#) _____	(SS#) _____	(SS#) _____
Child Attends School?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
Child's Race (See codes listed below)	Race Code # _____	Race Code # _____	Race Code # _____	Race Code # _____
Child's Ethnicity	RACE CODES: <b>1</b> White; <b>2</b> Black/African American; <b>3</b> American Indian/Alaskan Native; <b>4</b> Asian; <b>5</b> Spanish American/Hispanic; <b>6</b> Native Hawaiian or Other Pacific Islander; <b>9</b> Other or Unknown. Hispanic/Latino <input type="checkbox"/> YES <input type="checkbox"/> NO	Hispanic/Latino <input type="checkbox"/> YES <input type="checkbox"/> NO	Hispanic/Latino <input type="checkbox"/> YES <input type="checkbox"/> NO	Hispanic/Latino <input type="checkbox"/> YES <input type="checkbox"/> NO
Does Child Have Health Insurance Now? (See instructions for further explanation)	If <b>YES</b> , Please Fill in the Following Information: Type of Policy: _____ Company Name: _____ Policy ID # _____ <input type="checkbox"/> YES <input type="checkbox"/> NO	If <b>YES</b> , Please Fill in the Following Information: Type of Policy: _____ Company Name: _____ Policy ID # _____ <input type="checkbox"/> YES <input type="checkbox"/> NO	If <b>YES</b> , Please Fill in the Following Information: Type of Policy: _____ Company Name: _____ Policy ID # _____ <input type="checkbox"/> YES <input type="checkbox"/> NO	If <b>YES</b> , Please Fill in the Following Information: Type of Policy: _____ Company Name: _____ Policy ID # _____ <input type="checkbox"/> YES <input type="checkbox"/> NO
Has Child Had Health Insurance in the Past 4 Months? (See instructions for further explanation)	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
Why Did Insurance End in the Past 4 Months? (See reasons below)	Reason # _____ Other _____	Reason # _____ Other _____	Reason # _____ Other _____	Reason # _____ Other _____
<b>REASONS CHILD'S HEALTH INSURANCE ENDED: (See instructions)</b> <b>1</b> Parent or stepparent changed jobs or stopped employment and no other employer contributes to the cost of family coverage. <b>2</b> Parent or stepparent's employer stopped contributing to the cost of family coverage and no other employer contributes to the cost of family coverage. <b>3</b> Insurance company discontinued coverage because child is uninsurable. <b>4</b> Cost of insurance exceeded 10% of monthly income (before taxes). <b>5</b> Insurance stopped/dropped by someone other than parent or stepparent living with child. <b>6</b> Stopped/dropped a COBRA policy. <b>7</b> Other				



## Step 4

### Income Information:

Complete the section below for each parent, stepparent and child living in the home receiving income. List each source of income separately. Include income from jobs, self-employment, child support, Social Security benefits, unemployment compensation, and any other income received. List all income amounts before taxes and other deductions (gross income). Do not include income received by guardians, grandparents or other relatives. If there is no family income, write "NONE" in the chart below. (See instructions for explanation of all types of income that must be listed and the proof of income that must be provided.)

Person Receiving Income	Employer's Name or Source of Income?	Is Employer a State or Local Government?	How Much Income is Received?	How Often is Income Received?
First Name MI Last Name		<input type="checkbox"/> YES <input type="checkbox"/> NO	\$ _____	<input type="checkbox"/> Weekly <input type="checkbox"/> Every Two Weeks <input type="checkbox"/> Twice a Month <input type="checkbox"/> Monthly <input type="checkbox"/> Yearly
First Name MI Last Name		<input type="checkbox"/> YES <input type="checkbox"/> NO	\$ _____	<input type="checkbox"/> Weekly <input type="checkbox"/> Every Two Weeks <input type="checkbox"/> Twice a Month <input type="checkbox"/> Monthly <input type="checkbox"/> Yearly
First Name MI Last Name		<input type="checkbox"/> YES <input type="checkbox"/> NO	\$ _____	<input type="checkbox"/> Weekly <input type="checkbox"/> Every Two Weeks <input type="checkbox"/> Twice a Month <input type="checkbox"/> Monthly <input type="checkbox"/> Yearly
First Name MI Last Name		<input type="checkbox"/> YES <input type="checkbox"/> NO	\$ _____	<input type="checkbox"/> Weekly <input type="checkbox"/> Every Two Weeks <input type="checkbox"/> Twice a Month <input type="checkbox"/> Monthly <input type="checkbox"/> Yearly
First Name MI Last Name		<input type="checkbox"/> YES <input type="checkbox"/> NO	\$ _____	<input type="checkbox"/> Weekly <input type="checkbox"/> Every Two Weeks <input type="checkbox"/> Twice a Month <input type="checkbox"/> Monthly <input type="checkbox"/> Yearly

We have your permission to get information from the above employers, if necessary, about dates of employment and earnings. ☐ YES ☐ NO

## Step 5

### Childcare Expenses:

Do you pay someone to provide childcare while you work? ☐ YES ☐ NO If yes, provide information for each child in childcare.

(Child's name: First, MI, Last)	How much do you pay? \$ _____	How often?	(Child's name: First, MI, Last)	How much do you pay? \$ _____	How often?	(Child's name: First, MI, Last)	How much do you pay? \$ _____	How often?

You're almost done. Turn the page over, complete the application and remember to sign it.

## Step 6 Help with Medical Bills:

If the child is eligible, FAMIS Plus may be able to help you with medical/dental services the child received in the last 3 months. Did any child you are applying for receive medical/dental services in the last 3 months? ☐ YES ☐ NO

If yes, list names of children and months in which they received medical/dental services:

Provide proof of income for the months that child received medical/dental care. **DO NOT SEND MEDICAL/DENTAL BILLS TO FAMIS.**

## Step 7 Release:

If you would like to have someone else contact us for you, please complete the following:

I authorize (name) \_\_\_\_\_

and/or (organization) \_\_\_\_\_

(address) \_\_\_\_\_

(city) \_\_\_\_\_ (state) \_\_\_\_\_ (zip) \_\_\_\_\_ (phone) \_\_\_\_\_

to request and receive eligibility/enrollment information relating to my child(ren). I also permit FAMIS, the local Department of Social Services, and/or the Department of Medical Assistance Services to release information about this application to this person/organization.

By signing below I certify that I have read my **Rights and Responsibilities** (located on the instructions page) and agree to all the conditions and terms. I also agree that all information I have given on this application is true and correct to the best of my knowledge and belief. I understand that if I give false information, withhold information, or fail to report required changes promptly or on purpose, my children's health insurance may be denied or ended and I could be prosecuted for perjury, larceny and/or fraud.

SIGNATURE (REQUIRED) \_\_\_\_\_

DATE \_\_\_\_\_



# Children's Health Insurance

Application Instructions & Rights and Responsibilities

## APPLICATION INSTRUCTIONS FOR FAMIS & FAMIS Plus

(FAMIS Plus is the new name for children's Medicaid)

### How do I apply?

To get started, simply call our toll-free number **1-866-87-FAMIS (1-866-873-2647)** or fill out this application and mail it to **FAMIS P.O. Box 1820, Richmond, Virginia 23218-1820**, or fax it to **toll-free fax number 1-888-221-9402**. This application can also be mailed, dropped off or faxed to the **local Department of Social Services** in the City or County in which you live. Check the blue pages in your telephone book for the address and telephone number of your local Department of Social Services. It is not required that you visit FAMIS or your local Department of Social Services to apply.

### Who can apply for a child?

Parents can apply for their children. An adult relative with whom the child lives may also sign an application on behalf of the child. An adult who has legal custody or guardianship may apply for a child but will need to attach a copy of court papers. A person authorized in writing, by a parent or legal guardian, to act on behalf of the parent may apply but must attach a signed authorization from the parent. Adults, married to a minor, may apply for their spouse, and children over 18 or emancipated by a court, may apply for themselves.

**Step 1 Information on person completing application:** Complete this section listing your name, address and phone number. If we may call you at work, include that phone number. Please tell us what language you prefer. Write the name of the language you prefer in the space provided, such as:

English, Spanish, Cambodian, Vietnamese, Farsi, Haitian-Creole, Laotian, Chinese, Korean, Somali, Kurdish, Arabic, French, German, Japanese, or any other language.

**Step 2 Information on children:** Provide information on all children under 21 who live in the home with you even if they are not applying for FAMIS or FAMIS Plus. Although you can only apply for children under age 19 on this form, we need information on all children under 21 to correctly determine the size of the family. If there are more than 4 children under age 21 in the home, complete sections 2 and 3 on another application and attach it to this one.

List the **name** of each child under age 21 who lives in the home with you, tell us how they are **related to you**, their **date of birth**, and check if they are **male or female**.

For each child under age 21 in the home please write the **name** of the child's **parents and/or stepparents** living in the home with the child. Check if they are the Mother, Father or Stepparent of the child. The Social Security Number (SS#) of each parent is not required information but it helps us check income and process the application. If you prefer, you may leave it blank.

**Step 3 Information on children applying:** Write the **name** of each child at the top of the same column again. Check whether you are **applying for health insurance** for each child. If you are not applying for health insurance for a child, you do not need to answer the rest of the questions in this section for that child. If you are applying for the child, answer all of the questions in the column.

If the child is a **US citizen** check yes. If the child is a **legal immigrant**, provide the child's INS #, country of birth and the date the child entered the U.S. Children who are legal residents may qualify for these health insurance programs. You must provide a copy of the front and back of the child's Resident Alien Card or other proof of immigration status with this application. This information is for our records only and will not affect the immigration status of your children and will not be shared with the INS. We do not need information on the immigration status of any adults in your family. The INS cannot use this application to deny you admission to the U.S., to harm your permanent resident status, or to deport you.

Unless you are applying solely for emergency medical services for a non-citizen child, a **Social Security Number** is required for all children

applying for health insurance. If the child does not have a Social Security Number, you must provide proof that you have applied for one for the child.

Tell us if the child is currently **attending school**.

Enter the correct code number for the **Race** of each child. Codes are listed below the question on the application. Then check yes or no if the child is of Hispanic/Latino ethnic origin.

Having other health insurance does not affect a child's eligibility for FAMIS Plus but may affect eligibility for FAMIS. Tell us if your children have health **insurance now**, and what type of policy they have. (For example, comprehensive coverage, major medical, school-accident plan, dental coverage, etc.) Provide the name of the insurance company and the policy number.

Children are not eligible for FAMIS until they have been uninsured for 4 months unless there was a "good cause" **reason why the health insurance ended**. Tell us if each child had health insurance during the past **4 months**. If they did, tell us about the policy and the date it ended. Read the good cause reasons listed on the application and if any of them are true for this case, write the correct reason number in the space. If none of these reasons are correct, put #7 for "Other" and write a brief explanation of why the insurance ended. If the child's insurance was stopped because of the cost, (reason #4) you must provide proof of the monthly cost of the discontinued insurance. If the child's coverage was discontinued by an insurance company for a reason other than non-payment of premiums (reason #3), provide proof of this from the insurance company. If you want a further explanation of the good cause reasons or more information on what to include with the application, call **1-866-87-FAMIS** or your **local Department of Social Services**. **This rule does not apply to FAMIS Plus.**

**Step 4 Income information:** For each parent, stepparent and child under age 21 who lives in the home and receives income, list their **name** and the **source of the income**. If the income is from a job, list the name of the employer. If the income is from another source, (such as child support, unemployment compensation, Social Security, etc.) write the type or source of the income. Check if the person works for the **State of Virginia** or for a **local government agency**.

For each type of income listed, write the **amount of income** received and how often it is received (**each week, every two weeks, twice a month, once a month or yearly**). Be sure to write the amount of income before any taxes or other deductions are taken out (gross income).

You also need to provide **proof of each type of income** a family member receives. You will need to provide proof of all income received in the month before you apply. (For example, if you were

applying in June, you would need to attach proof of all income received in the month of May. If you were applying in May you would need to provide proof of all income for April.)

To prove income from a job, please attach a copy of all paycheck stubs for last month showing gross pay. If you do not have paycheck stubs, you can send a signed letter from an employer stating how much the employee was paid for each pay period last month or you may call 1-866-87-FAMIS to request a special form for reporting employment income. If you are self-employed, provide your most current tax return and all schedules or business records for last month.

You must also provide proof of other types of income received. Examples of proof of other income include: Child support — a print out from the Division of Child Support Enforcement Web site for last month, or copies of all child support checks received last month, or a signed statement from the absent parent stating how much they pay each month; Social Security (SSA or SSI) — the current year award letter from the Social Security Administration; unemployment compensation — a copy of all checks received last month.

If income is different from month to month, you may provide proof of the last 3 months of income to show an average income. If you have questions about what income to report or what proof is needed, please call 1-866-87-FAMIS or your local Department of Social Services.

Permission to contact employers: In some situations we may need to contact employers to get information about earnings. If you agree to let us do this in order to process this application, check yes.

**Step 5 Childcare Expenses:** Certain childcare expenses may help a child qualify for FAMIS Plus. Tell us if you **pay for childcare while** you work. If the answer is yes, write the **name** of each child in paid childcare and how much you pay for their childcare and how often you pay it. (For example, \$50 a week or \$200 a month.) You can even report this expense if you are paying a relative to care for the children. Also, report payments you make for adult daycare for an adult in your home that needs special care while you work.

**Step 6 Medical Bills:** If a child qualifies for FAMIS Plus, you may be able to get help with the child's **medical and dental bills for the past 3 months**. Tell us if a child applying for insurance has any medical bills during the last 3 months. If the answer is yes, write the **name** of the child or children who have medical bills and the **month** in which the child or children received the medical or dental service. You will also have to show proof of family income for that month so we can determine if the child or children would have qualified for FAMIS Plus at the time the medical care was received. If a child qualifies for FAMIS instead of FAMIS Plus, medical bills will only be covered from the first day of the month in which your signed application was received by FAMIS or at the local Department of Social Services. **DO NOT SEND MEDICAL OR DENTAL BILLS TO FAMIS OR FAMIS Plus.** If the child qualifies for this retroactive coverage, we can pay for bills submitted by doctors, hospitals, dentists, pharmacies, or other medical providers for medical/dental services provided to the child during that time. We cannot pay for bills sent from individuals.

**Step 7 RELEASE:** If someone has helped you with this application or you would like someone else to be able to receive information about this application on your behalf, **clearly print the person's name** or the name of an **organization** in this section. We will not release any information about this application to anyone except you, unless you tell us here who you want to be able to receive this information.

Before you sign this application, make sure all the information is correct and read the section on your **Rights and Responsibilities** carefully. When you sign the application you are agreeing to all the statements under the Rights and Responsibilities. **Sign and date the application.** We cannot process an unsigned application.

**Final checklist:** ☐ Did you answer all the questions?  
☐ Did you attach proof of all of last month's income?  
☐ Did you attach any other necessary documents?  
☐ Did you sign the application?

**Mail or fax to FAMIS or your local Department of Social Services today.**

## YOUR RIGHTS AND RESPONSIBILITIES

(Read this section before signing the application)

### I have the right to:

- Be treated fairly and equally regardless of my race, color, religion, national origin, gender, political beliefs, or disability consistent with state and federal law and I can file a complaint if I feel I have been discriminated against.
- Request, in writing, a hearing or review of any negative action that affects my child(ren)'s eligibility for or receipt of FAMIS or FAMIS Plus (formerly Medicaid) insurance, including timely decisions made on this application. I understand that there will be no opportunity for review of a negative action if the sole basis for the action is lack of funding for FAMIS.
- Receive services from the Division of Child Support Enforcement and receive the booklet "Child Support and You". I further understand that failure to apply for such services will not affect my child(ren)'s eligibility for FAMIS or FAMIS Plus.

### I further understand and agree that:

- This application could lead to my child(ren)'s enrollment in either FAMIS **OR** FAMIS Plus and that my child will be enrolled in the appropriate program based on eligibility rules.
- My children are not eligible for FAMIS coverage if they are eligible for FAMIS Plus, if they are eligible for health coverage under the Commonwealth of Virginia's State Employee Health Insurance Plan, or if they are patients in an institution for mental diseases. Children who are inmates in a public correctional institution are ineligible for both FAMIS and FAMIS Plus.
- The State and its contractors may contact other state and federal agencies to verify any information that affects my child(ren)'s eligibility for insurance.
- The State and its contractors may exchange information on this application

and medical, health, or other information relating to my child(ren)'s coverage with other agencies and contractors, including companies offering health insurance to my child(ren), to assist with application, enrollment, administration, quality control, and quality assurance. We will not share your information with the IRS or the INS.

- The Commonwealth of Virginia or its designee has the right to receive payments for services and supplies from insurance companies and other liable sources as reimbursement for medical services received by my child(ren).

- Each provider of medical services to my child(ren) may release any medical or other information necessary for the provider to be paid.

### If my child is enrolled in FAMIS, I understand:

- I will be responsible for paying a co-payment for some FAMIS services received by my child(ren) and the FAMIS case will be maintained by the FAMIS Central Processing Unit (CPU).
- I have the responsibility to report within 10 days of the change, certain increases in income or changes in family size as explained in the FAMIS handbook and if the child enrolled in FAMIS moves out of the state of Virginia. I must report such changes to the FAMIS CPU at 1-866-873-2647.

### If my child is enrolled in FAMIS Plus, I understand:

- That FAMIS Plus was formerly known as Medicaid. The FAMIS Plus case will be maintained by the local Department of Social Services where the child lives.
- I have the responsibility to report any changes in information provided on this form within 10 days of the change. I must report this information to the local Department of Social Services that maintains the child's FAMIS Plus case.

FAMIS AND FAMIS PLUS MUST BE RENEWED AT LEAST **EVERY 12 MONTHS**.

IT IS VERY IMPORTANT THAT YOU REPORT ANY CHANGE IN YOUR ADDRESS TO THE AGENCY THAT IS MANAGING THE CHILD'S CASE. IF WE DO NOT HAVE A CORRECT ADDRESS, WE WILL NOT BE ABLE TO NOTIFY YOU WHEN IT IS TIME TO RENEW COVERAGE AND THE CHILD WILL BE CANCELLED FROM THE PROGRAM.

**HELP US KEEP YOUR CHILDREN COVERED — TELL US IF YOU MOVE!**

### FAMIS ALIEN ELIGIBILITY CHART

QUALIFIED ALIEN GROUPS	ARRIVED BEFORE AUGUST 22, 1996	ARRIVED ON OR AFTER AUGUST 22, 1996	
		1 <sup>ST</sup> 5 YEARS	AFTER 5 YEARS
Qualified aliens who are Veterans or Active Military (includes spouses/dependent children); certain American Indians Form DD 214-veteran	Eligible	Eligible	Eligible
Permanent Resident Aliens (Aliens lawfully admitted for permanent residence), except Amerasians I-151; AR-3a; I-551; I-327; I-688B-274a.12(a)(1)	Eligible	NOT Eligible	Eligible
Conditional entrants-aliens admitted Pursuant to 8 U.S.C. 1153(a)(7), section 203(a)(7) of the INA I-94	Eligible	NOT Eligible	Eligible
Aliens paroled in the US pursuant to 8 U.S.C. 1182(d)(5), section 212(d)(5) of the INA I-94; I-688B – 274a(12)(c)(11)	Eligible	NOT Eligible	Eligible
Battered aliens, alien parents of battered children, alien children of battered parents U.S. Attorney General	Eligible	NOT Eligible	Eligible
	<b>ELIGIBLE REGARDLESS OF ENTRY DATE OR LENGTH OF RESIDENCE</b>		
Aliens granted asylum pursuant to section 208 of the INA I-94; I-688B – 274a.12(a)(5)	Eligible		
Aliens admitted as refugees pursuant to section 207 of the INA, or as Cuban or Haitian Entrants pursuant to section 501(e) of the Refugee Education Assistance Act of 1980, or Amerasians I-551; I-94; I-688B	Eligible		
Aliens whose deportation has been withheld pursuant to Section 243(h) or 241(b)(3) of the INA I-688-B – 274a.12(a)(10) Immigration Judge's Order	Eligible		
Victims of a severe form of trafficking pursuant to the Trafficking Victims Protection Act of 2000 (P.L. 106-386) [ORR certification/eligibility letter]	Eligible		

<b>UNQUALIFIED ALIEN GROUPS</b> <b><u>NOT</u> ELIGIBLE REGARDLESS OF ENTRY DATE OR LENGTH OF RESIDENCE</b>
Aliens residing in the US pursuant to an indefinite stay of deportation (I-94; Immigration Letter)
Aliens residing in the US pursuant to an indefinite voluntary departure (I-94; Immigration Letter)
Aliens on whose behalf an immediate relative petition has been approved and their families covered by the petition who are entitled to voluntary departure under 8 CFR 242.5(a)(2)(vi) and whose departure the INS does not contemplate enforcing (I-94; I-210)
Aliens who have filed an application for adjustment of status pursuant to §245 INA that the INS has accepted as properly filed and whose departure the INS does not contemplate enforcing (I-181; Endorsed Passport)
Aliens granted stay of deportation by court order, statute or regulation, or by individual determination of the INS whose departure the agency does not contemplate enforcing (I-94; Court Order; INS Letter)
Aliens granted voluntary departure pursuant to section 242(b) of the INA whose departure the INS does not contemplate enforcing (I-94; I-210; I-688B – 247a.12(a)(11) or (13))
Aliens granted deferred action status pursuant to INS Operations Instruction 103.1(a)(ii) prior to 6/15/84 or 242.1a22 issued 6/15/84 and later (I-210; INS Letter)
Aliens residing in the U.S. under orders of supervision (I-220B)
Aliens who entered before January 1972 and have continuously resided in the U.S. since January 1972 (Case Record)
Aliens granted suspension of deportation pursuant to Section 244 of the INA and whose deportation the INS does not contemplate enforcing (Immigration Judge Court Order)
Any other aliens living in the US with the knowledge and permission of the INS whose departure the agency does not contemplate enforcing (INS Contact)
Illegal aliens – aliens not lawfully admitted or whose lawful admission status has expired
Visitors (non-immigrants): tourists, diplomats, foreign students, temporary workers, etc. (I-688B – 274a.12(b)(1)-(20); I-94; I-185; I-1186; SW-434; I-95A)